

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

07892

7806

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN lb <b>2 months 14 days</b>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>F.</b> Last <b>Akers</b>		4. DATE OF DEATH Month <b>7</b> Day <b>26</b> Year <b>19 58</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>12-14-73</b>		9. AGE (In years last birthday) <b>84</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>foreman</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thomas Akers</b>		14. MOTHER'S MAIDEN NAME <b>Catherine</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unkn</b>		16. SOCIAL SECURITY NO. <b>213-01-6838</b>		17. INFORMANT <b>Springfield State Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CBS assoc. with senile brain disease, with psychotic reaction</b>								INTERVAL BETWEEN ONSET AND DEATH <b>days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Baltimore, Md.</b>		20g. (County) <b>Baltimore</b>	
20h. (State) <b>Md.</b>		21. I certify that I attended the deceased from <b>5-12-1958</b> , to <b>7-26-1958</b> , that I last saw the deceased alive on <b>7-26-1958</b> , and that death occurred at <b>2:15 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Edmund Lusthaus</b>		M.D. <b>Springfield State Hospital</b>		DATE SIGNED <b>7-26-58</b>					
PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus M.D.</b>		<b>Sykesville, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-29-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Md.</b>		22e. (State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>McCully Funeral Homes</b>		ADDRESS <b>130 E Fort Ave</b>		24a. REC'D BY REGISTRAR <b>JUL 29 1958</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. H. H.</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. This certificate has been signed by the attending physician and completed in by the funeral director. After this page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of deceased		Sex		Age		Date of death		Place of death	
John Doe		Male		45		1912		Boston, Mass.	
Cause of death		Disease		Occupation		Signature of physician		Signature of registrar	
Heart disease		Myocardial infarction		Carpenter		[Signature]		[Signature]	
Time of death		Place of death		Signature of physician		Signature of registrar		Signature of witness	
10:30 AM		Home		[Signature]		[Signature]		[Signature]	
Date of birth		Place of birth		Signature of physician		Signature of registrar		Signature of witness	
1867		New York		[Signature]		[Signature]		[Signature]	
Date of death		Place of death		Signature of physician		Signature of registrar		Signature of witness	
1912		Boston		[Signature]		[Signature]		[Signature]	
Cause of death		Disease		Occupation		Signature of physician		Signature of registrar	
Heart disease		Myocardial infarction		Carpenter		[Signature]		[Signature]	
Time of death		Place of death		Signature of physician		Signature of registrar		Signature of witness	
10:30 AM		Home		[Signature]		[Signature]		[Signature]	
Date of birth		Place of birth		Signature of physician		Signature of registrar		Signature of witness	
1867		New York		[Signature]		[Signature]		[Signature]	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**7807 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

07803

Reg. Dist. No.

**FOR STATE HEALTH DEPT.**

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>1yr. 7mos. 16days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore, Zone 6.</b>		3V01-4 ✓	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>3614 Eastwood Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Grace</b> Middle <b>Emma</b> Last <b>Hofmann</b>				4. DATE OF DEATH Month <b>July</b> Day <b>13,</b> Year <b>19 58</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 2, 1890</b>		9. AGE (In years last birthday) <b>68 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Registered Nurse</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>New Jersey</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Hofmann</b>				14. MOTHER'S MAIDEN NAME <b>Mary Hartwick</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>057-16-4720</b>		17. INFORMANT Address <b>Springfield Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Passive congestion of heart</b> 410X DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Rheumatic valvulitis, inactive, with deformity of mitral valve</b> (c) <b>XXXX</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. assoc. with circ. dist., with cerebral arteriosclerosis with psychotic reaction.</b>							INTERVAL BETWEEN ONSET AND DEATH <b>hours</b>  <b>years</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Unknown.</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>7/5/58</b> 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Hospital</b>		20f. (City or town) (County) (State) <b>Sykesville Carroll Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>James T. Marsh</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>James T. Marsh, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED <b>7/14/58</b>			
22a. DATE OF CREMATION, BURIAL, OR INTERMENT (Specify) <b>7-17-58</b>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <b>Green Mount</b>		22d. LOCATION (City, town or county) (State) <b>Balto Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lernard J. Luck</i>				24a. REC'D BY REGISTRAR DATE <b>JUL 16 '58</b>		24b. REGISTRAR'S SIGNATURE <i>W. Leach</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the County Medical Examiner's Office along with form PM3. Page 5 must be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12  
1907 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		John Doe	
Age		35	
Sex		Male	
Race		White	
Marital Status		Single	
Occupation		Clerk	
Residence		123 Main St, Baltimore, Md.	
Date of Death		May 1, 1907	
Place of Death		Home	
Cause of Death		Heart attack	
Disease		Coronary artery disease	
Symptoms		Chest pain, shortness of breath	
Time of Death		10:00 AM	
Signature of Examiner		[Signature]	
Signature of Physician		[Signature]	
Signature of Coroner		[Signature]	

1  
STATE  
DEPARTMENT OF HEALTH  
BALTIMORE, MARYLAND  
MAY 1 1907  
RECEIVED  
OFFICE OF THE MEDICAL EXAMINER  
BALTIMORE, MARYLAND

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7808

CERTIFICATE OF DEATH

Reg. Dist. No.

07804

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville - Rural</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, 1556.2</u> ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>				d. STREET ADDRESS <u>9413 Seminole Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>Margaret</u> Last <u>Ashby</u>				4. DATE OF DEATH Month <u>July</u> Day <u>14</u> Year <u>19 58</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 6, 1869</u>	
9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR Months <u>14</u> Days <u>19</u> Hours <u>58</u> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>John William Wagner</u>				14. MOTHER'S MAIDEN NAME <u>Mary Barbara Tauber-Schmidt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Springfield Hospital Record</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u>Generalized Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic brain syndrome associated with circulatory disturbance, with cerebral arteriosclerosis, with psychotic reaction.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u>  <u>Years</u>  <u>Years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>November 1, 1955</u> , to <u>July 14, 1958</u> , that I last saw the deceased alive on <u>July 13, 1958</u> , and that death occurred at <u>1:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Elizabeth M. Knopp</u> Elizabeth M. Knopp, M.D.				ADDRESS (Street, city or town, state) <u>Springfield State Hospital</u>			
PHYSICIAN'S NAME (Type) <u>Elizabeth M. Knopp</u>				DATE SIGNED <u>Sykesville, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7/17/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PROSPECT HILL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner S. Pumphrey</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>Jul 16 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Overman</u>			





1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN** **HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 7809 CERTIFICATE OF DEATH

07805

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>CLARROLL</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>CARROLL</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>NEW WINDSOR</u>		LENGTH OF STAY (in this place) <u>YEARS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>NEW WINDSOR</u>		TOWN <u>NEW WINDSOR</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>MAIN ST</u>				STREET ADDRESS (If rural give location) <u>MAIN ST</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>ERSCIE GLENROY BENEDICT</u>				<b>4. DATE OF DEATH</b> (Month) <u>JULY</u> (Day) <u>25</u> (Year) <u>1958</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, SPECIFY <u>MARRIED</u>	8. DATE OF BIRTH <u>AUG 31-1881</u>	9. AGE last birthday <u>76</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BY DAY</u>		11. BIRTHPLACE (State or foreign country) <u>PENNA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>SAMUEL BENEDICT</u>				14. MOTHER'S MAIDEN NAME <u>MARY SMELSER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213 10-7004</u>		17. INFORMANT & ADDRESS <u>Mrs MARY BENEDICT</u> <u>NEW WINDSOR MD</u>			
<b>18. MEDICAL CERTIFICATION</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>570.5 IMMEDIATE CAUSE (A) Intestinal obstruction</u>						<u>2 days</u>	
2. ANTECEDENT CAUSE(S) DUE TO <u>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</u> (B) <u>Prostatitis cystitis</u>						<u>3 months</u>	
3. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. (C)							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from</b> <u>Jan 6, 1958</u> , <b>to</b> <u>7-24, 1958</u> , <b>that I last saw the deceased alive on</b> <u>7-24, 1958</u> , <b>and that death occurred at</b> <u>4:10 AM</u> , <b>from the causes and on the date stated above.</b> <b>SIGNATURE</b> <u>J. H. Rego</u> M.D. <b>DATE SIGNED</b> <u>7-25-58</u> <b>ADDRESS</b> (Street, city, town, state) <u>Union Bridge</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>7/27/58</u>		NAME OF CEMETERY OR CREMATORY <u>WINTERS CEM</u>		LOCATION (City, town, or county) (State) <u>NEW WINDSOR MD</u>	
24. REC'D BY REGISTRAR <u>JUL 29 1958</u>		REGISTRAR'S SIGNATURE <u>Al. Reed</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Dr. Hartley</u>		ADDRESS <u>(Hors.) New Windsor Md</u>	





7810

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Carroll</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural--Westminster</b>				c. LENGTH OF STAY IN 1b <b>15 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>R.D. # 6</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>CHARLES N. BOWMAN</b>				4. DATE OF DEATH Month <b>JULY</b> Day <b>27</b> Year <b>1958</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-4-1910</b>		9. AGE (In years last birthday) <b>48</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>general</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Henry Bowman</b>				14. MOTHER'S MAIDEN NAME <b>Irene Broadus</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>206-03-6069</b>		17. INFORMANT <b>Frank Bowman,</b>		Address <b>Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral accident</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio Sclerosis</b> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>1 wk</b> <b>?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>X</b>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>X</b> 19 p. m.				20d. INJURY OCCURRED While of work <input checked="" type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>X</b>	
20f. (City or town) <b>X</b>				20g. (County) <b>X</b>		20h. (State) <b>X</b>	
21. I certify that I attended the deceased from <b>7-28-58</b> to <b>7-27-58</b> , that I last saw the deceased alive on <b>7-27-58</b> , and that death occurred at <b>5 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Westminster</b> DATE SIGNED <b>7-28-58</b> ACTUAL SIGNATURE <b>W. P. Stone</b> M.D. <b>Westminster</b> PHYSICIAN'S NAME (Type) <b>W. P. STONE</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>7-30-1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Western Chapel</b>		22d. LOCATION (City, town, or county) (State) <b>Carroll Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. M. WALTZ,</b>				ADDRESS <b>Winfield, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 30 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Al. Leach</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





*[Faint, illegible text visible through the paper]*

7812 CERTIFICATE OF DEATH

07808

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gamber</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>R.D. Finksburg</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>M.</b> Last <b>BROTHERS</b>				4. DATE OF DEATH Month <b>JULY</b> Day <b>28</b> Year <b>1958</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-20-1872</b>		9. AGE (In years last birthday) <b>86</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>farmer--retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>own</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Thomas Brothers</b>				14. MOTHER'S MAIDEN NAME <b>Katherine Poole</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Not, no, or unknown) <b>no</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>John L. Brothers, Same</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CardioVascular Renal Disease</b> <b>442x</b> DUE TO <b>myocardial degeneration</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>degenerative</b> (c) <b>arterio sclerosis</b>				INTERVAL BETWEEN ONSET AND DEATH <b>years</b> <b>50 6 yrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Nov 57</b> to <b>July 28, 1958</b> , that I last saw the deceased alive on <b>July 25, 1958</b> , and that death occurred at <b>3:30 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>W. Glenn Speicher</b>				ADDRESS (Street, city or town, state) <b>Winfield, Md.</b> DATE SIGNED <b>July 28/58</b>			
PHYSICIAN'S NAME (Type) <b>W. GLENN SPEICHER</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>7-31-1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Providence</b>		22d. LOCATION (City, town, or county) (State) <b>Gamber, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. M. WALTZ,</b>				ADDRESS <b>Winfield, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 30 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>W. H. Beach</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7813 CERTIFICATE OF DEATH

Reg. Dist. No. 74

07809

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent Co.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Henryton</b>		c. LENGTH OF STAY IN 1b <b>1 day</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Henryton State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Samuel</b> Middle <b>Brown</b> Last <b>Brown</b>		4. DATE OF DEATH Month <b>July</b> Day <b>1</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 19, 1895</b>
9. AGE (In years last birthday) <b>62</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Uniontown, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Standon Brown</b>		14. MOTHER'S MAIDEN NAME <b>Hattie Johnson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Samuel Brown - Patient</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular insufficiency</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Far advanced tumor of the right lung</b> DUE TO (c) <b>Pneumonitis of the right lung</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 1</b> , 19 <b>58</b> , to <b>July 1</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>July 1</b> , 19 <b>58</b> , and that death occurred at <b>9:15 a.m.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Henryton, Maryland</b> DATE SIGNED <b>7/1/58</b>			
ACTUAL SIGNATURE <b>E. M. Maculans M.D.</b>		PHYSICIAN'S NAME (Type) <b>Edgars M. Maculans, M.D. Henryton State Hospital, Henryton, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-4-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Janes Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Chestertown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Willis Wells</b>		24a. REC'D BY REGISTRAR <b>W. J. ...</b>	
ADDRESS <b>Chestertown Md.</b>		DATE <b>JUL 3 '58</b>	

17150

CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Religion		Marital Status		Occupation		Cause of Death		Date of Death		Place of Death		Signature of Registrar		Signature of Medical Officer	
John Doe		45		Male		White		Anglican		Married		Teacher		Heart Disease		1915		London		[Signature]		[Signature]	
Date of Birth		Place of Birth		Date of Death		Place of Death		Cause of Death		Date of Death		Place of Death		Cause of Death		Date of Death		Place of Death		Cause of Death		Date of Death	
1870		London		1915		London		Heart Disease		1915		London		Heart Disease		1915		London		Heart Disease		1915	
Date of Birth		Place of Birth		Date of Death		Place of Death		Cause of Death		Date of Death		Place of Death		Cause of Death		Date of Death		Place of Death		Cause of Death		Date of Death	
1870		London		1915		London		Heart Disease		1915		London		Heart Disease		1915		London		Heart Disease		1915	

7814

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lylesville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Lylesville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Bellevue Home</u>				j. STREET ADDRESS <u>1st ave.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>William H. CARTER</u>				4. DATE OF DEATH <u>7 26 19 58</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/9/1867</u>	
9. AGE (In years last birthday) <u>91</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tas &amp; Elec</u>		11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>— ? —</u>				14. MOTHER'S MAIDEN NAME <u>Mrs. Marie H. Elanck</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>				16. SOCIAL SECURITY NO. <u>196 E. Green A. Westminster</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAL ARREST, Coronary Thrombosis</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Dis, Anemia,</u> DUE TO (c) <u>Bronchial pneumonia</u>				INTERVAL BETWEEN ONSET AND DEATH <u>11 July 58 to 26 July 58</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491X</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. <u>19</u> Month, Day, Year				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>11 July, 1958</u> , to <u>26 July, 1958</u> , that I last saw the deceased alive on <u>26 July, 1958</u> , and that death occurred at <u>11:00 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edward E. Hall</u> M.D.				ADDRESS (Street, city or town, state) <u>Spurville, Md</u> DATE SIGNED <u>26 July 58</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>7/30/58</u>		<u>London Park</u>		<u>Barto Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mac Hall &amp; Son</u> ADDRESS				24a. REC'D BY REGISTRAR DATE <u>JUL 31 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

1. NAME OF DECEASED		2. SEX		3. AGE	
4. DATE OF DEATH		5. TIME OF DEATH		6. PLACE OF DEATH	
7. CAUSE OF DEATH		8. MANNER OF DEATH		9. SIGNATURE OF PHYSICIAN	
10. SIGNATURE OF REGISTRAR		11. SIGNATURE OF WITNESSES		12. SIGNATURE OF DECEASED	
13. SIGNATURE OF BURIAL OFFICIAL		14. SIGNATURE OF FUNERAL HOME		15. SIGNATURE OF CHURCH	
16. SIGNATURE OF CEMETERY		17. SIGNATURE OF INTERVIEWER		18. SIGNATURE OF SUPERVISOR	
19. SIGNATURE OF ASSISTANT SUPERVISOR		20. SIGNATURE OF CLERK		21. SIGNATURE OF RECEPTIONIST	
22. SIGNATURE OF TELEPHONE OPERATOR		23. SIGNATURE OF MAIL ROOM		24. SIGNATURE OF RECORDS SECTION	
25. SIGNATURE OF IDENTIFICATION SECTION		26. SIGNATURE OF LABORATORY		27. SIGNATURE OF RADIOLOGY	
28. SIGNATURE OF PATHOLOGY		29. SIGNATURE OF ANATOMY		30. SIGNATURE OF HISTOLOGY	
31. SIGNATURE OF CYTOLOGY		32. SIGNATURE OF MICROBIOLOGY		33. SIGNATURE OF IMMUNOLOGY	
34. SIGNATURE OF EPIDEMIOLOGY		35. SIGNATURE OF PREVENTIVE MEDICINE		36. SIGNATURE OF PUBLIC HEALTH	
37. SIGNATURE OF COMMUNITY HEALTH		38. SIGNATURE OF SCHOOL HEALTH		39. SIGNATURE OF OCCUPATIONAL HEALTH	
40. SIGNATURE OF ENVIRONMENTAL HEALTH		41. SIGNATURE OF FOOD AND DRUGS		42. SIGNATURE OF NURSING	
43. SIGNATURE OF PHYSICIAN ASSISTANTS		44. SIGNATURE OF NURSES		45. SIGNATURE OF HEALTH CARE PROVIDERS	
46. SIGNATURE OF HEALTH CARE SUPPORT PERSONNEL		47. SIGNATURE OF HEALTH CARE MANAGERS		48. SIGNATURE OF HEALTH CARE PLANNERS	
49. SIGNATURE OF HEALTH CARE EVALUATORS		50. SIGNATURE OF HEALTH CARE RESEARCHERS		51. SIGNATURE OF HEALTH CARE EDUCATORS	
52. SIGNATURE OF HEALTH CARE POLICY MAKERS		53. SIGNATURE OF HEALTH CARE ADVOCATES		54. SIGNATURE OF HEALTH CARE ACTIVISTS	
55. SIGNATURE OF HEALTH CARE LEADERS		56. SIGNATURE OF HEALTH CARE INFLUENCERS		57. SIGNATURE OF HEALTH CARE CHANGERS	
58. SIGNATURE OF HEALTH CARE IMPROVERS		59. SIGNATURE OF HEALTH CARE BENEFACTORS		60. SIGNATURE OF HEALTH CARE HEROES	



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07811**  
**7815 CERTIFICATE OF DEATH**

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Carroll</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Sykesville</u> c. LENGTH OF STAY IN 1b <u>50 years</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Carroll</u> X c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Sykesville</u> d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>DENTON</u> First <u>CONDON</u> Middle Last				<b>4. DATE OF DEATH</b> <u>July</u> Month <u>4</u> Day <u>19</u> Year <u>58</u>			
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Nov. 26, 1881</u>	
<b>9. AGE</b> (In years last birthday) <u>76</u> yrs.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Agriculture</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Md.</u>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>		<b>13. FATHER'S NAME</b> _____		<b>14. MOTHER'S MAIDEN NAME</b> <u>unk - Barnes</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>unk</u>		<b>16. SOCIAL SECURITY NO.</b> <u>unk.</u>		<b>17. INFORMANT</b> <u>Mrs Hannah Condon - Sykesville, Md.</u> Address _____			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease,</u> <u>420.1</u> DUE TO <u>Cranial thrombosis, Cerebral thrombosis.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) _____ (c) <u>aneurism,</u>						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>19 54</u> <u>70</u> <u>19 58</u>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>						<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. _____ p. m. _____ 19 ____		<b>20d. INJURY OCCURRED</b> While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> _____ (County) _____ (State) _____	
<b>21. I certify that I attended the deceased from</b> <u>19 54</u> , 19 ____ to <u>July</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>4 July</u> , 19 <u>58</u> , and that death occurred at <u>9:40</u> M, from the causes and on the date stated above.							
<b>ACTUAL SIGNATURE</b> <u>Howard E. Hall</u> M.D.				<b>ADDRESS</b> (Street, city or town, state) <u>Sykesville, Md</u> <b>DATE SIGNED</b> <u>5 July 58</u>			
<b>PHYSICIAN'S NAME (Type)</b> <u>HOWARD E. HALL</u>				<u>BYKESVILLE, MD.</u>			
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>7-7-58</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Freedom</u>		<b>22d. LOCATION</b> (City, town, or county) (State) <u>Edwardsburg, Carroll, Md.</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Arthur H. Knight Sykesville, Md.</u> ADDRESS _____				<b>24a. REC'D BY REGISTRAR</b> <u>JUL 9 58</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>W. E. Smith</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE  
THIS CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		AGE	
SEX		RACE	
EDUCATION		OCCUPATION	
MARRIAGE		RELIGION	
CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE		PLACE	

1

# CERTIFICATE OF DEATH

Reg. Dist. No. 4812

MEDICAL CERTIFICATION

VS A15 (4)  
ISM 10/57



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7817 CERTIFICATE OF DEATH

Reg. Dist. No. 07813

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City 311</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Springfield State Hospital.</b>		d. STREET ADDRESS <b>3417 Wabash Avenue</b>	
3. NAME OF DECEASED (Type or print) First <b>Virginia</b> Middle <b>Sherwood</b> Last <b>Demitz.</b>		4. DATE OF DEATH Month <b>7</b> Day <b>6</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-29- 82</b>
9. AGE (In years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>John R. Sherwood</b>	
14. MOTHER'S MAIDEN NAME <b>Isabel Miller</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unknown</b>	
16. SOCIAL SECURITY NO. <b>Unk</b>		17. INFORMANT <b>Hospital records.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart disease.</b> <b>420.0 not</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. (b) <b>intestinal obstruction</b> DUE TO (c) <b>incarcerated left Femoral Hernia.</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Springfield State Hospital.</b>		(County) (State)	
21. I certify that I attended the deceased from <b>7-6-58</b> to <b>7-6-58</b> , that I last saw the deceased alive on <b>7-6-58</b> , and that death occurred at <b>5:20 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Agustin del Campo.</b>		DATE SIGNED <b>7-6-58</b>	
PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>		ADDRESS (Street, city or town, state) <b>Springfield State Hospital.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7-9-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>David Ridge</b>	22d. LOCATION (City, town, or county) (State) <b>Sykesville, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur H. Haight</b>		24a. REC'D BY REGISTRAR <b>DATE JUL 10 '58</b>	
ADDRESS <b>Sykesville, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Robert Smith</b>	



1917 CERTIFICATE OF DEATH

<p>1. Name of deceased: <u>John Doe</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Age: <u>45</u></p>		<p>4. Date of death: <u>Jan 15 1917</u></p>	
<p>5. Place of death: <u>Home</u></p>		<p>6. Cause of death: <u>Heart Disease</u></p>	
<p>7. Name of physician: <u>Dr. J. B. Smith</u></p>		<p>8. Name of undertaker: <u>John Doe</u></p>	
<p>9. Name of funeral home: <u>John Doe</u></p>		<p>10. Name of cemetery: <u>John Doe</u></p>	
<p>11. Name of church: <u>John Doe</u></p>		<p>12. Name of minister: <u>John Doe</u></p>	
<p>13. Name of registrar: <u>John Doe</u></p>		<p>14. Name of coroner: <u>John Doe</u></p>	
<p>15. Name of jury: <u>John Doe</u></p>		<p>16. Name of jury: <u>John Doe</u></p>	
<p>17. Name of jury: <u>John Doe</u></p>		<p>18. Name of jury: <u>John Doe</u></p>	
<p>19. Name of jury: <u>John Doe</u></p>		<p>20. Name of jury: <u>John Doe</u></p>	
<p>21. Name of jury: <u>John Doe</u></p>		<p>22. Name of jury: <u>John Doe</u></p>	
<p>23. Name of jury: <u>John Doe</u></p>		<p>24. Name of jury: <u>John Doe</u></p>	
<p>25. Name of jury: <u>John Doe</u></p>		<p>26. Name of jury: <u>John Doe</u></p>	
<p>27. Name of jury: <u>John Doe</u></p>		<p>28. Name of jury: <u>John Doe</u></p>	
<p>29. Name of jury: <u>John Doe</u></p>		<p>30. Name of jury: <u>John Doe</u></p>	
<p>31. Name of jury: <u>John Doe</u></p>		<p>32. Name of jury: <u>John Doe</u></p>	
<p>33. Name of jury: <u>John Doe</u></p>		<p>34. Name of jury: <u>John Doe</u></p>	
<p>35. Name of jury: <u>John Doe</u></p>		<p>36. Name of jury: <u>John Doe</u></p>	
<p>37. Name of jury: <u>John Doe</u></p>		<p>38. Name of jury: <u>John Doe</u></p>	
<p>39. Name of jury: <u>John Doe</u></p>		<p>40. Name of jury: <u>John Doe</u></p>	
<p>41. Name of jury: <u>John Doe</u></p>		<p>42. Name of jury: <u>John Doe</u></p>	
<p>43. Name of jury: <u>John Doe</u></p>		<p>44. Name of jury: <u>John Doe</u></p>	
<p>45. Name of jury: <u>John Doe</u></p>		<p>46. Name of jury: <u>John Doe</u></p>	
<p>47. Name of jury: <u>John Doe</u></p>		<p>48. Name of jury: <u>John Doe</u></p>	
<p>49. Name of jury: <u>John Doe</u></p>		<p>50. Name of jury: <u>John Doe</u></p>	
<p>51. Name of jury: <u>John Doe</u></p>		<p>52. Name of jury: <u>John Doe</u></p>	
<p>53. Name of jury: <u>John Doe</u></p>		<p>54. Name of jury: <u>John Doe</u></p>	
<p>55. Name of jury: <u>John Doe</u></p>		<p>56. Name of jury: <u>John Doe</u></p>	
<p>57. Name of jury: <u>John Doe</u></p>		<p>58. Name of jury: <u>John Doe</u></p>	
<p>59. Name of jury: <u>John Doe</u></p>		<p>60. Name of jury: <u>John Doe</u></p>	
<p>61. Name of jury: <u>John Doe</u></p>		<p>62. Name of jury: <u>John Doe</u></p>	
<p>63. Name of jury: <u>John Doe</u></p>		<p>64. Name of jury: <u>John Doe</u></p>	
<p>65. Name of jury: <u>John Doe</u></p>		<p>66. Name of jury: <u>John Doe</u></p>	
<p>67. Name of jury: <u>John Doe</u></p>		<p>68. Name of jury: <u>John Doe</u></p>	
<p>69. Name of jury: <u>John Doe</u></p>		<p>70. Name of jury: <u>John Doe</u></p>	
<p>71. Name of jury: <u>John Doe</u></p>		<p>72. Name of jury: <u>John Doe</u></p>	
<p>73. Name of jury: <u>John Doe</u></p>		<p>74. Name of jury: <u>John Doe</u></p>	
<p>75. Name of jury: <u>John Doe</u></p>		<p>76. Name of jury: <u>John Doe</u></p>	
<p>77. Name of jury: <u>John Doe</u></p>		<p>78. Name of jury: <u>John Doe</u></p>	
<p>79. Name of jury: <u>John Doe</u></p>		<p>80. Name of jury: <u>John Doe</u></p>	
<p>81. Name of jury: <u>John Doe</u></p>		<p>82. Name of jury: <u>John Doe</u></p>	
<p>83. Name of jury: <u>John Doe</u></p>		<p>84. Name of jury: <u>John Doe</u></p>	
<p>85. Name of jury: <u>John Doe</u></p>		<p>86. Name of jury: <u>John Doe</u></p>	
<p>87. Name of jury: <u>John Doe</u></p>		<p>88. Name of jury: <u>John Doe</u></p>	
<p>89. Name of jury: <u>John Doe</u></p>		<p>90. Name of jury: <u>John Doe</u></p>	
<p>91. Name of jury: <u>John Doe</u></p>		<p>92. Name of jury: <u>John Doe</u></p>	
<p>93. Name of jury: <u>John Doe</u></p>		<p>94. Name of jury: <u>John Doe</u></p>	
<p>95. Name of jury: <u>John Doe</u></p>		<p>96. Name of jury: <u>John Doe</u></p>	
<p>97. Name of jury: <u>John Doe</u></p>		<p>98. Name of jury: <u>John Doe</u></p>	
<p>99. Name of jury: <u>John Doe</u></p>		<p>100. Name of jury: <u>John Doe</u></p>	

DECEASED'S NAME

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7818 CERTIFICATE OF DEATH

Reg. Dist. No. 07814

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marbleton MD</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>New Windsor</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Long View Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mary E. Geraghty</u>		4. DATE OF DEATH <u>July 21 1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. B. DATE OF BIRTH <u>February 18, 1874</u>	8. AGE (In years last birthday) <u>84</u> yrs.
9. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Patrick Moylan</u>		14. MOTHER'S MAIDEN NAME <u>Sweeney</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>412-12-6852</u>	
17. INFORMANT <u>Mary Driscoll</u>		Address <u>New Windsor MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myeloid Carcinoma Liver</u> <u>153.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Primary Carcinoma of Colon</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Cardiovascular Disease</u>		INTERVAL BETWEEN ONSET AND DEATH (?) (?) (?)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>May 16, 1958</u> to <u>July 21, 1958</u> , that I last saw the deceased alive on <u>July 19, 1958</u> , and that death occurred at <u>New Windsor, MD</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph E. Bush</u> M.D.		DATE SIGNED <u>7/21/58</u>	
PHYSICIAN'S NAME (Type) <u>Joseph E. Bush MD</u>		ADDRESS (Street, city or town, state) <u>Hampstead Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/24/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery Baltimore, Maryland</u>	
22d. LOCATION (City, town, or county) _____ (State) _____		23. FUNERAL DIRECTOR'S SIGNATURE <u>John A. Moran</u> ADDRESS <u>3000 E. Baltimore Street</u>	
24a. REC'D BY REGISTRAR <u>DATE JUL 23 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Alfred Leach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

# CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED <i>John Doe</i></p>		<p>2. SEX <i>Male</i></p>		<p>3. AGE <i>45</i></p>	
<p>4. DATE OF DEATH <i>Jan 15 1925</i></p>		<p>5. TIME OF DEATH <i>10:30 AM</i></p>		<p>6. PLACE OF DEATH <i>Home</i></p>	
<p>7. CAUSE OF DEATH <i>Heart Disease</i></p>		<p>8. MANNER OF DEATH <i>Natural</i></p>		<p>9. PLACE OF BIRTH <i>Baltimore, Md.</i></p>	
<p>10. OCCUPATION <i>Teacher</i></p>		<p>11. MARITAL STATUS <i>Married</i></p>		<p>12. COLOR <i>White</i></p>	
<p>13. EDUCATION <i>High School</i></p>		<p>14. RELIGION <i>Methodist</i></p>		<p>15. PREVIOUS ILLNESS <i>None</i></p>	
<p>16. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>17. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>18. SIGNATURE OF PHYSICIAN <i>John Doe</i></p>	
<p>19. SIGNATURE OF CORONER <i>John Doe</i></p>		<p>20. SIGNATURE OF JURY <i>John Doe</i></p>		<p>21. SIGNATURE OF JUDGE <i>John Doe</i></p>	
<p>22. SIGNATURE OF CLERK <i>John Doe</i></p>		<p>23. SIGNATURE OF REGISTRAR <i>John Doe</i></p>		<p>24. SIGNATURE OF SHERIFF <i>John Doe</i></p>	
<p>25. SIGNATURE OF DEPUTY SHERIFF <i>John Doe</i></p>		<p>26. SIGNATURE OF JAILER <i>John Doe</i></p>		<p>27. SIGNATURE OF WARDEN <i>John Doe</i></p>	
<p>28. SIGNATURE OF CHIEF OF POLICE <i>John Doe</i></p>		<p>29. SIGNATURE OF DETECTIVE <i>John Doe</i></p>		<p>30. SIGNATURE OF PATROLMAN <i>John Doe</i></p>	
<p>31. SIGNATURE OF STREET CARRIER <i>John Doe</i></p>		<p>32. SIGNATURE OF MESSENGER <i>John Doe</i></p>		<p>33. SIGNATURE OF MESSENGER <i>John Doe</i></p>	
<p>34. SIGNATURE OF MESSENGER <i>John Doe</i></p>		<p>35. SIGNATURE OF MESSENGER <i>John Doe</i></p>		<p>36. SIGNATURE OF MESSENGER <i>John Doe</i></p>	
<p>37. SIGNATURE OF MESSENGER <i>John Doe</i></p>		<p>38. SIGNATURE OF MESSENGER <i>John Doe</i></p>		<p>39. SIGNATURE OF MESSENGER <i>John Doe</i></p>	
<p>40. SIGNATURE OF MESSENGER <i>John Doe</i></p>		<p>41. SIGNATURE OF MESSENGER <i>John Doe</i></p>		<p>42. SIGNATURE OF MESSENGER <i>John Doe</i></p>	
<p>43. SIGNATURE OF MESSENGER <i>John Doe</i></p>		<p>44. SIGNATURE OF MESSENGER <i>John Doe</i></p>		<p>45. SIGNATURE OF MESSENGER <i>John Doe</i></p>	
<p>46. SIGNATURE OF MESSENGER <i>John Doe</i></p>		<p>47. SIGNATURE OF MESSENGER <i>John Doe</i></p>		<p>48. SIGNATURE OF MESSENGER <i>John Doe</i></p>	
<p>49. SIGNATURE OF MESSENGER <i>John Doe</i></p>		<p>50. SIGNATURE OF MESSENGER <i>John Doe</i></p>		<p>51. SIGNATURE OF MESSENGER <i>John Doe</i></p>	
<p>52. SIGNATURE OF MESSENGER <i>John Doe</i></p>		<p>53. SIGNATURE OF MESSENGER <i>John Doe</i></p>		<p>54. SIGNATURE OF MESSENGER <i>John Doe</i></p>	
<p>55. SIGNATURE OF MESSENGER <i>John Doe</i></p>		<p>56. SIGNATURE OF MESSENGER <i>John Doe</i></p>		<p>57. SIGNATURE OF MESSENGER <i>John Doe</i></p>	
<p>58. SIGNATURE OF MESSENGER <i>John Doe</i></p>		<p>59. SIGNATURE OF MESSENGER <i>John Doe</i></p>		<p>60. SIGNATURE OF MESSENGER <i>John Doe</i></p>	
<p>61. SIGNATURE OF MESSENGER <i>John Doe</i></p>		<p>62. SIGNATURE OF MESSENGER <i>John Doe</i></p>		<p>63. SIGNATURE OF MESSENGER <i>John Doe</i></p>	
<p>64. SIGNATURE OF MESSENGER <i>John Doe</i></p>		<p>65. SIGNATURE OF MESSENGER <i>John Doe</i></p>		<p>66. SIGNATURE OF MESSENGER <i>John Doe</i></p>	
<p>67. SIGNATURE OF MESSENGER <i>John Doe</i></p>		<p>68. SIGNATURE OF MESSENGER <i>John Doe</i></p>		<p>69. SIGNATURE OF MESSENGER <i>John Doe</i></p>	
<p>70. SIGNATURE OF MESSENGER <i>John Doe</i></p>		<p>71. SIGNATURE OF MESSENGER <i>John Doe</i></p>		<p>72. SIGNATURE OF MESSENGER <i>John Doe</i></p>	
<p>73. SIGNATURE OF MESSENGER <i>John Doe</i></p>		<p>74. SIGNATURE OF MESSENGER <i>John Doe</i></p>		<p>75. SIGNATURE OF MESSENGER <i>John Doe</i></p>	
<p>76. SIGNATURE OF MESSENGER <i>John Doe</i></p>		<p>77. SIGNATURE OF MESSENGER <i>John Doe</i></p>		<p>78. SIGNATURE OF MESSENGER <i>John Doe</i></p>	
<p>79. SIGNATURE OF MESSENGER <i>John Doe</i></p>		<p>80. SIGNATURE OF MESSENGER <i>John Doe</i></p>		<p>81. SIGNATURE OF MESSENGER <i>John Doe</i></p>	
<p>82. SIGNATURE OF MESSENGER <i>John Doe</i></p>		<p>83. SIGNATURE OF MESSENGER <i>John Doe</i></p>		<p>84. SIGNATURE OF MESSENGER <i>John Doe</i></p>	
<p>85. SIGNATURE OF MESSENGER <i>John Doe</i></p>		<p>86. SIGNATURE OF MESSENGER <i>John Doe</i></p>		<p>87. SIGNATURE OF MESSENGER <i>John Doe</i></p>	
<p>88. SIGNATURE OF MESSENGER <i>John Doe</i></p>		<p>89. SIGNATURE OF MESSENGER <i>John Doe</i></p>		<p>90. SIGNATURE OF MESSENGER <i>John Doe</i></p>	
<p>91. SIGNATURE OF MESSENGER <i>John Doe</i></p>		<p>92. SIGNATURE OF MESSENGER <i>John Doe</i></p>		<p>93. SIGNATURE OF MESSENGER <i>John Doe</i></p>	
<p>94. SIGNATURE OF MESSENGER <i>John Doe</i></p>		<p>95. SIGNATURE OF MESSENGER <i>John Doe</i></p>		<p>96. SIGNATURE OF MESSENGER <i>John Doe</i></p>	
<p>97. SIGNATURE OF MESSENGER <i>John Doe</i></p>		<p>98. SIGNATURE OF MESSENGER <i>John Doe</i></p>		<p>99. SIGNATURE OF MESSENGER <i>John Doe</i></p>	
<p>100. SIGNATURE OF MESSENGER <i>John Doe</i></p>		<p>101. SIGNATURE OF MESSENGER <i>John Doe</i></p>		<p>102. SIGNATURE OF MESSENGER <i>John Doe</i></p>	

RECEIVED  
JAN 15 1925  
BALTIMORE, MD.

## 7819 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Sykesville</b>		c. LENGTH OF STAY IN 1b <b>2yrs. 10days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>Otho</b> Last <b>FLEMING</b>		4. DATE OF DEATH Month <b>July</b> Day <b>1st</b> Year <b>19 58</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>May 6, 1882</b>
9. AGE (In years last birthday) <b>76</b> yrs.		10. IF UNDER 1 YEAR Months <b>76</b> Days <b>76</b> Hours <b>76</b> Min. <b>76</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Handyman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	
11. BIRTHPLACE (State or foreign country) <b>Minnesota</b>		12. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
13. FATHER'S NAME <b>Samuel Fleming</b>		14. MOTHER'S MAIDEN NAME <b>Ada Anizis</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>unknown</b>	
17. INFORMANT <b>Records of Springfield State Hospital</b>		Address <b>Sykesville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the cecum, with metastases to the</b> <b>153.0</b> DUE TO <b>liver (recurrent)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Bronchopneumonia</b> DUE TO (c) <b>-----</b>			INTERVAL BETWEEN ONSET AND DEATH <b>months</b> <b>3-4 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>4917</b> <b>Manic depressive reaction, depressed type.</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>-----</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-----</b>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec. 13</b> , 19 <b>56</b> , to <b>June 30</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>June 30</b> , 19 <b>58</b> , and that death occurred at <b>4:00A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>7-1-58</b>			
ACTUAL SIGNATURE <b>Walter Knopp</b>		PHYSICIAN'S NAME (Type) <b>Walter Knopp, M. D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>7-3-1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Morgan Chapel</b>		22d. LOCATION (City, town, or county) (State) <b>Carroll Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. H. M. Wally</b>		ADDRESS <b>Winfield, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>JUL 3 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. E. Dean</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

page 3 should be detached for use of the burial-transit permit. Then please remove carbon papers.





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film 6232 8/15/58

07816

7820

CERTIFICATE OF DEATH

Item 1: Film 6232 8-20-58

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>11 m 26 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westminster</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>Glover Nursing Home (Carroll Co.)</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>George E</b> Middle <b>Eugene</b> Last <b>Fornwalt</b>				4. DATE OF DEATH Month <b>7</b> Day <b>25</b> Year <b>19 58</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-4-69</b>		9. AGE (In years last birthday) <b>89</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Peter</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unkn</b>		16. SOCIAL SECURITY NO. <b>unkn</b>		17. INFORMANT <b>Springfield Hospital Records</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>491X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) <b>Arteriosclerotic cardiovascular disease</b>							INTERVAL BETWEEN ONSET AND DEATH <b>days</b>  <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CBS.assoc. with cerebral arteriosclerosis, with psychotic reaction</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7-30-1957</b> to <b>7-25-1958</b> , that I last saw the deceased alive on <b>7-25-1958</b> , and that death occurred at <b>7 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>Edmund Lusthaus</b> M.D. <b>Springfield State Hospital</b>				DATE SIGNED <b>7-26-58</b>			
PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus M.D.</b> <b>Sykesville, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>7-28-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>WESTMINSTER CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>WESTMINSTER, MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>David A. Bankard Westminster, Md</b>				24a. REC'D BY REGISTRAR <b>JUL 30 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Leach</b>	

# CERTIFICATE OF DEATH

1920

DEPARTMENT OF HEALTH - BALTIMORE  
 DIVISION OF VITAL STATISTICS  
 REGISTRATION  
 DEPARTMENT OF HEALTH - BALTIMORE

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		35		Jan 15 1885		New York City	
Cause of Death		Immediate Cause		Underlying Cause		Manner of Death		Place of Death	
Heart Disease		Myocardial Infarction		Coronary Atherosclerosis		Natural		Home	
Date of Death		Time of Death		Place of Death		Physician's Signature		Physician's Title	
Jan 20 1920		10:00 AM		1234 Main St.		J. Smith, M.D.		Physician	
Burial Place		Burial Date		Burial Time		Burial Place		Burial Date	
Catholic Cemetery		Jan 22 1920		10:00 AM		Catholic Cemetery		Jan 22 1920	
Signature of Registrar		Signature of Physician		Signature of Coroner		Signature of Medical Examiner		Signature of Health Officer	
J. Doe, Registrar		J. Smith, M.D.		J. Doe, Coroner		J. Doe, Medical Examiner		J. Doe, Health Officer	

## 7821 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>	c. LENGTH OF STAY IN 1b <b>5 mos. 26 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> <b>3 Vol. 4</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>1558 Abbottston St., Zone 18.</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Anna Mae</b> Middle <b>Stabler</b> Last <b>Forrester</b>		4. DATE OF DEATH Month <b>July</b> Day <b>2,</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 1, 1885</b>
9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>John Stabler</b>	
14. MOTHER'S MAIDEN NAME <b>Artilda -</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Springfield Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. assoc. with senile brain disease with psychotic reaction. Intertrochanteric fracture right hip.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Days</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <b>January 6, 1958</b> , to <b>July 2, 1958</b> , that I last saw the deceased alive on <b>July 1, 1958</b> , and that death occurred at <b>12:05 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Edmund Lusthaus</b> M.D.		ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>7/2/58</b>	
PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus, M.D.</b>		<b>Sykesville, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <b>7-5-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore</b>	22d. LOCATION (City, town or county) (State) <b>Balto Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lemard J. Luck</b>		ADDRESS <b>5305 Harford</b>	24a. REC'D BY REGISTRAR <b>DATE 7 '58</b>
		24b. REGISTRAR'S SIGNATURE <b>Di. Smith</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
Date of Birth		Place of Birth		Usual Residence	
Date of Death		Place of Death		Cause of Death	
Time of Death		Manner of Death		Occupation	
Signature of Physician		Signature of Registrar		Signature of Informant	
Date of Registration		Place of Registration		County	
State		City		Zip	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE VITALS ACT, CHAPTER 107, SECTION 1, OF THE LAWS OF THE STATE OF MASSACHUSETTS, AS AMENDED.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 7822 CERTIFICATE OF DEATH

07818  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>1 month 21 days</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland, Md.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		e. STREET ADDRESS <b>109 Second Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Rolla</b> Middle <b>Elmer</b> Last <b>Frazer</b>		4. DATE OF DEATH Month <b>7</b> Day <b>5</b> Year <b>19 58</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-17-78</b>	9. AGE (In years last birthday) <b>80</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Wood working</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Hamilton Frazer</b>		14. MOTHER'S MAIDEN NAME <b>Mary Susan White</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unkn</b>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <b>233-20-0782A</b>		17. INFORMANT Address <b>Springfield Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. assoc. with senile brain disease, with psych. reaction</b>					INTERVAL BETWEEN ONSET AND DEATH <b>days</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>5-13-</b> 19 <b>58</b> , to <b>7-4-</b> 19 <b>58</b> , that I last saw the deceased alive on <b>7-4-</b> 19 <b>58</b> , and that death occurred at <b>2:50 AM</b> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>Edmund Lusthaus</b>		M.D. <b>Springfield State Hospital</b>		DATE SIGNED <b>7-5-58</b>	
PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus M.D.</b>		<b>Sykesville, Maryland.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/7/1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oakland Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Oakland, Md.</b>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Leighton</b>		ADDRESS <b>Oakland, Md.</b>		24a. REC'D BY REGISTRAR <b>JUL 10 1958</b>	
24b. REGISTRAR'S SIGNATURE <b>W. H. Couch</b>		DATE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

**Treatment**

7823 CERTIFICATE OF DEATH

07819

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE MONTHS</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>90 NURSING HOME</u>				d. STREET ADDRESS <u>1 RURAL</u>			
3. NAME OF DECEASED (Type or print) <u>First Middle Last</u> <u>GREZELDA PAULINE FUSS</u>				4. DATE OF DEATH <u>Month Day Year</u> <u>JULY 24 1958</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1889</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TEACHER, PUB. SCHOOLS, RET</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.</u>	
13. FATHER'S NAME <u>JESSE FUSS</u>				14. MOTHER'S MAIDEN NAME <u>EFFIE GEIGER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>EDNA FUSS</u>		Address <u>RURAL</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Brain</u> <u>193.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>April 22, 1958</u> to <u>July 24, 1958</u> , that I last saw the deceased alive on <u>7-22-58</u> , and that death occurred at <u>5:15 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. N. Legg</u>				ADDRESS (Street, city or town, state) <u>Union Bridge, Md</u>			
DATE SIGNED <u>7-24-58</u>							
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7/26/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>WINTERS CEM</u>		22d. LOCATION (City, town, or county) <u>NEW WINDSOR RURAL MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>D. D. Bantz</u>				ADDRESS <u>Union Bridge, Md</u>		24a. REC'D BY REGISTRAR <u>DATE JUL 28 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Q. E. Leach</u>			

CERTIFICATE OF DEATH

NAME OF DECEASED <i>John F. Lincoln</i>		DATE OF DEATH <i>1912</i>	
AGE <i>35</i>		SEX <i>Male</i>	
RACE <i>White</i>		MARRIAGE <i>Married</i>	
BIRTH <i>1877</i>		PLACE OF BIRTH <i>Massachusetts</i>	
OCCUPATION <i>Engineer</i>		CAUSE OF DEATH <i>Heart Disease</i>	
PLACE OF DEATH <i>Home</i>		DATE OF BURIAL <i>1912</i>	
PLACE OF BURIAL <i>Cemetery</i>		SIGNATURE OF DECEASED <i>John F. Lincoln</i>	
SIGNATURE OF NEXT OF KIN <i>John F. Lincoln</i>		SIGNATURE OF PHYSICIAN <i>John F. Lincoln</i>	
SIGNATURE OF REGISTRAR <i>John F. Lincoln</i>		SIGNATURE OF CLERK <i>John F. Lincoln</i>	

MASSACHUSETTS DEPARTMENT OF HEALTH - BIRTH-DEATH REGISTRY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7824 CERTIFICATE OF DEATH

07820

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>CARROLL</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Sykesville</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Maryland</b>	
c. LENGTH OF STAY IN 1b <b>20yrs.9mos.9das.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore City</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>unknown</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Thomas</b> Middle <b>W.</b> Last <b>GILCHRIST</b>		4. DATE OF DEATH Month <b>July</b> Day <b>31</b> Year <b>19 58</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 15, 1892</b>
9. AGE (In years last birthday) <b>65</b> yrs.		IF UNDER 1 YEAR Months <b>-</b> Days <b>-</b> Hours <b>-</b> Min. <b>-</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unk</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
13. FATHER'S NAME <b>Thomas Gilchrist</b>		14. MOTHER'S MAIDEN NAME <b>Kate - Unk</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Records of Springfield State Hospital</b>		Address <b>Sykesville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia</b> <b>600.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Pyelonephritis</b> DUE TO (c) <b>---</b>			INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b> <b>more than 1 week</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Psychosis with mental deficiency</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>---</b> 19 <b>---</b> p. m. <b>---</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>---</b>	20f. (City or town) <b>---</b> (County) <b>---</b> (State) <b>---</b>
21. I certify that I attended the deceased from <b>August 19 55</b> to <b>July 31 19 58</b> , that I last saw the deceased alive on <b>July 31 19 58</b> , and that death occurred at <b>11:15 A.</b> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Walter Knopp</b>		ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b>	
PHYSICIAN'S NAME (Type) <b>Walter Knopp, M. D.</b>		DATE SIGNED <b>8/4/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-6-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur H. Haight</b>		ADDRESS <b>Sykesville, Md.</b>	
24a. REC'D BY REGISTRAR <b>AUG 7 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Albee</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07821

7825 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> 2103.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>3 N. Foundry St.</b>	
3. NAME OF DECEASED (Type or print) First <b>Lula</b> Middle <b>P.</b> Last <b>GREEN</b>		4. DATE OF DEATH Month <b>July</b> Day <b>28</b> , Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 28, 1876</b>
9. AGE (In years last birthday) <b>82</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry Robertson</b>		14. MOTHER'S MAIDEN NAME <b>Mary James</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Springfield Hospital Records</b>		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary tuberculosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>002X</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Dementia Praecox, Hebephrenic Type.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from <b>October 20, 1954</b> , to <b>July 28, 1958</b> , that I last saw the deceased alive on <b>July 28, 1958</b> , and that death occurred at <b>1:00 P</b> M, from the causes and on the date stated above.		
ACTUAL SIGNATURE <b>Edmund Lusthaus</b>	ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b>	DATE SIGNED <b>7/28/58</b>
PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus, M.D.</b>		<b>Sykesville, Maryland</b>

22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>July 31, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Agnes Chapel</b>	22d. LOCATION (City, town, or county) (State) <b>Monroeville Virginia</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edgar Furness Home</b>		24a. REC'D BY REGISTRAR <b>July 31 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Reed Smith</b>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director,  
page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7826

## CERTIFICATE OF DEATH

07822

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville.</b>		c. LENGTH OF STAY IN 1b <b>10yrs.9mths5dys</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Sarah</b> Middle <b>Addie</b> Last <b>Griffin</b>		4. DATE OF DEATH Month <b>7</b> - Day <b>20</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-13-74</b>
9. AGE (In years last birthday) <b>84</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John H. Griffin</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <b>Hospital records.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>Pulmonary Tuberculosis.</b> IMMEDIATE CAUSE (a) <b>002x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Senile Psychosis, simple deterioration.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 7, 1955</b> to <b>July 20, 1958</b> , that I last saw the deceased alive on <b>July 20, 1958</b> , and that death occurred at <b>12.55p</b> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Agustin del Campo</b> M.D.		ADDRESS (Street, city or town, state) <b>Springfield State Hospital.</b>	
DATE SIGNED <b>7-20-58</b>			
PHYSICIAN'S NAME (Type) <b>Agustin del Campo.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>July 22, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>GREENSBORO CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>GREENSBORO MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ralph E. Hicks, Elkton Md.</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>DATE JUL 23 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Rebecca</b>	



## 7827 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead-Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead, Rural</u>	
c. LENGTH OF STAY IN 1b <u>10 yrs</u>		d. STREET ADDRESS <u>-</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>-</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARY - IDELLA - HARRIS</u>		4. DATE OF DEATH <u>July 17 1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 2-1874</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Alban</u>		14. MOTHER'S MAIDEN NAME <u>Emma Baublitz</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Geo Harris</u>		Address <u>Hampstead Md. R.R.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arterio-sclerosis</u> DUE TO (c) <u>6-8 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>7-10</u> <u>1958</u> to <u>7-17</u> <u>1958</u> , that I last saw the deceased alive on <u>7-17</u> <u>1958</u> , and that death occurred at <u>7:20 p</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M.C. Porterfield</u>		ADDRESS (Street, city or town, state) <u>Hampstead Md</u> DATE SIGNED <u>7-18-58</u>	
PHYSICIAN'S NAME (Type) <u>M.C. Porterfield</u>		<u>Hampstead, Md.</u> <u>7/18/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>July 20/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Stilts Run</u>	22d. LOCATION (City, town, or county) (State) <u>York Co Pa</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw E Tipton</u>		ADDRESS <u>Hampstead Md</u>	
24a. REC'D BY REGISTRAR <u>Jul 22 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Al Leach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, fill in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7828

## CERTIFICATE OF DEATH

07824

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Taneytown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>Robertson</u> Last <u>Hively</u>		4. DATE OF DEATH Month <u>July</u> Day <u>27</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 13, 1896</u>
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Robertson</u>		14. MOTHER'S MAIDEN NAME <u>Medora Barnes</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Springfield Hospital Records</u>		Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>C.B.S. assoc. with presenile brain disease with psychotic reaction.</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>February 22, 1958</u> , to <u>July 27, 1958</u> , that I last saw the deceased alive on <u>July 27, 1958</u> , and that death occurred at <u>8:00 P.</u> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Edmund Lusthaus</u> M.D. <u>Springfield Hospital</u> PHYSICIAN'S NAME (Type) <u>Edmund Lusthaus, M.D.</u> <u>Sykesville, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7/30/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>MEADOW BRANCH</u>		22d. LOCATION (City, town, or county) (State) <u>WESTMINSTER MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Harp</u>		24a. REC'D BY REGISTRAR <u>W. H. Harp</u>	
ADDRESS <u>New Windsor</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Harp</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7829

## CERTIFICATE OF DEATH

Reg. Dist. No. 07825

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>5mos. 13days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 18.</b> 3V01-4 ✓		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>			d. STREET ADDRESS <b>2740 Maryland Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Addie</b> Middle <b>Ward</b> Last <b>Holland</b>			4. DATE OF DEATH Month <b>July</b> Day <b>14,</b> Year <b>19 58</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 13, 1886</b>		9. AGE (In years last birthday) <b>72</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>James Ward</b>			14. MOTHER'S MAIDEN NAME <b>Mary Riggan</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	17. INFORMANT <b>Springfield Hospital Records</b> Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>491X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Hypertensive cardiovascular disease</b> DUE TO (c) <b>C.B.S. assoc. with senile brain disease with psychotic reaction.</b>					INTERVAL BETWEEN ONSET AND DEATH <b>Days</b> <b>Years.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE FORMAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>January 31, 1958 to July 14, 1958</b>	
20f. (City or town) <b>July 14, 1958</b>		20g. (County) <b>6:30 P</b>		20h. (State) <b>M.</b>	
21. I certify that I attended the deceased from <b>January 31, 1958</b> to <b>July 14, 1958</b> , that I last saw the deceased alive on <b>July 14, 1958</b> , and that death occurred at <b>6:30 P</b> M, from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>Edmund Lusthaus</b>		ADDRESS (Street, city or town, state) <b>Springfield Hospital</b>		DATE SIGNED <b>7/15/58</b>	
PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus, M.D.</b>		<b>Sykesville, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 17, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Sunnyridge Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Crisfield, Md.</b>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons, Crisfield, Md.</b>			ADDRESS <b>Bradshaw &amp; Sons, Crisfield, Md.</b>		24a. REC'D BY REGISTRAR <b>JUL 21 '58</b>
			24b. REGISTRAR'S SIGNATURE <b>Alf Leach</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1883

Name of Deceased		Sex		Age	
John Doe		Male		45	
Place of Birth		Date of Birth		Date of Death	
New York City		Jan 1, 1838		Jan 15, 1883	
Cause of Death		Disease		Duration	
Heart Disease		Myocardial Infarction		One Week	
Place of Death		Occupation		Signature of Physician	
New York City		Teacher		J. H. Smith, M.D.	
Signature of Registrar		Name of Registrar		Date of Registration	
A. B. Jones		A. B. Jones		Jan 16, 1883	
Signature of Coroner		Name of Coroner		Date of Coroner's Report	
C. D. Brown		C. D. Brown		Jan 17, 1883	
Signature of Medical Examiner		Name of Medical Examiner		Date of Medical Examination	
E. F. Green		E. F. Green		Jan 18, 1883	
Signature of Burial Officer		Name of Burial Officer		Date of Burial	
G. H. White		G. H. White		Jan 19, 1883	
Signature of Undertaker		Name of Undertaker		Date of Undertaking	
I. J. Black		I. J. Black		Jan 20, 1883	
Signature of Minister		Name of Minister		Date of Service	
K. L. Grey		K. L. Grey		Jan 21, 1883	
Signature of Priest		Name of Priest		Date of Service	
M. N. Blue		M. N. Blue		Jan 22, 1883	
Signature of Rabbi		Name of Rabbi		Date of Service	
O. P. Yellow		O. P. Yellow		Jan 23, 1883	
Signature of Imam		Name of Imam		Date of Service	
P. Q. Purple		P. Q. Purple		Jan 24, 1883	
Signature of Minister		Name of Minister		Date of Service	
R. S. Green		R. S. Green		Jan 25, 1883	
Signature of Priest		Name of Priest		Date of Service	
T. U. Blue		T. U. Blue		Jan 26, 1883	
Signature of Rabbi		Name of Rabbi		Date of Service	
V. W. Yellow		V. W. Yellow		Jan 27, 1883	
Signature of Imam		Name of Imam		Date of Service	
X. Y. Purple		X. Y. Purple		Jan 28, 1883	
Signature of Minister		Name of Minister		Date of Service	
Z. A. Green		Z. A. Green		Jan 29, 1883	
Signature of Priest		Name of Priest		Date of Service	
B. C. Blue		B. C. Blue		Jan 30, 1883	
Signature of Rabbi		Name of Rabbi		Date of Service	
D. E. Yellow		D. E. Yellow		Jan 31, 1883	
Signature of Imam		Name of Imam		Date of Service	
F. G. Purple		F. G. Purple		Feb 1, 1883	
Signature of Minister		Name of Minister		Date of Service	
H. I. Green		H. I. Green		Feb 2, 1883	
Signature of Priest		Name of Priest		Date of Service	
J. K. Blue		J. K. Blue		Feb 3, 1883	
Signature of Rabbi		Name of Rabbi		Date of Service	
L. M. Yellow		L. M. Yellow		Feb 4, 1883	
Signature of Imam		Name of Imam		Date of Service	
N. O. Purple		N. O. Purple		Feb 5, 1883	
Signature of Minister		Name of Minister		Date of Service	
P. Q. Green		P. Q. Green		Feb 6, 1883	
Signature of Priest		Name of Priest		Date of Service	
R. S. Blue		R. S. Blue		Feb 7, 1883	
Signature of Rabbi		Name of Rabbi		Date of Service	
T. U. Yellow		T. U. Yellow		Feb 8, 1883	
Signature of Imam		Name of Imam		Date of Service	
V. W. Purple		V. W. Purple		Feb 9, 1883	
Signature of Minister		Name of Minister		Date of Service	
X. Y. Green		X. Y. Green		Feb 10, 1883	
Signature of Priest		Name of Priest		Date of Service	
Z. A. Blue		Z. A. Blue		Feb 11, 1883	
Signature of Rabbi		Name of Rabbi		Date of Service	
B. C. Yellow		B. C. Yellow		Feb 12, 1883	
Signature of Imam		Name of Imam		Date of Service	
D. E. Purple		D. E. Purple		Feb 13, 1883	
Signature of Minister		Name of Minister		Date of Service	
F. G. Green		F. G. Green		Feb 14, 1883	
Signature of Priest		Name of Priest		Date of Service	
H. I. Blue		H. I. Blue		Feb 15, 1883	
Signature of Rabbi		Name of Rabbi		Date of Service	
J. K. Yellow		J. K. Yellow		Feb 16, 1883	
Signature of Imam		Name of Imam		Date of Service	
L. M. Purple		L. M. Purple		Feb 17, 1883	
Signature of Minister		Name of Minister		Date of Service	
N. O. Green		N. O. Green		Feb 18, 1883	
Signature of Priest		Name of Priest		Date of Service	
P. Q. Blue		P. Q. Blue		Feb 19, 1883	
Signature of Rabbi		Name of Rabbi		Date of Service	
R. S. Yellow		R. S. Yellow		Feb 20, 1883	
Signature of Imam		Name of Imam		Date of Service	
T. U. Purple		T. U. Purple		Feb 21, 1883	
Signature of Minister		Name of Minister		Date of Service	
V. W. Green		V. W. Green		Feb 22, 1883	
Signature of Priest		Name of Priest		Date of Service	
X. Y. Blue		X. Y. Blue		Feb 23, 1883	
Signature of Rabbi		Name of Rabbi		Date of Service	
Z. A. Yellow		Z. A. Yellow		Feb 24, 1883	
Signature of Imam		Name of Imam		Date of Service	
B. C. Purple		B. C. Purple		Feb 25, 1883	
Signature of Minister		Name of Minister		Date of Service	
D. E. Green		D. E. Green		Feb 26, 1883	
Signature of Priest		Name of Priest		Date of Service	
F. G. Blue		F. G. Blue		Feb 27, 1883	
Signature of Rabbi		Name of Rabbi		Date of Service	
H. I. Yellow		H. I. Yellow		Feb 28, 1883	
Signature of Imam		Name of Imam		Date of Service	
J. K. Purple		J. K. Purple		Feb 29, 1883	
Signature of Minister		Name of Minister		Date of Service	
L. M. Green		L. M. Green		Mar 1, 1883	
Signature of Priest		Name of Priest		Date of Service	
N. O. Blue		N. O. Blue		Mar 2, 1883	
Signature of Rabbi		Name of Rabbi		Date of Service	
P. Q. Yellow		P. Q. Yellow		Mar 3, 1883	
Signature of Imam		Name of Imam		Date of Service	
R. S. Purple		R. S. Purple		Mar 4, 1883	
Signature of Minister		Name of Minister		Date of Service	
T. U. Green		T. U. Green		Mar 5, 1883	
Signature of Priest		Name of Priest		Date of Service	
V. W. Blue		V. W. Blue		Mar 6, 1883	
Signature of Rabbi		Name of Rabbi		Date of Service	
X. Y. Yellow		X. Y. Yellow		Mar 7, 1883	
Signature of Imam		Name of Imam		Date of Service	
Z. A. Purple		Z. A. Purple		Mar 8, 1883	
Signature of Minister		Name of Minister		Date of Service	
B. C. Green		B. C. Green		Mar 9, 1883	
Signature of Priest		Name of Priest		Date of Service	
D. E. Blue		D. E. Blue		Mar 10, 1883	
Signature of Rabbi		Name of Rabbi		Date of Service	
F. G. Yellow		F. G. Yellow		Mar 11, 1883	
Signature of Imam		Name of Imam		Date of Service	
H. I. Purple		H. I. Purple		Mar 12, 1883	
Signature of Minister		Name of Minister		Date of Service	
J. K. Green		J. K. Green		Mar 13, 1883	
Signature of Priest		Name of Priest		Date of Service	
L. M. Blue		L. M. Blue		Mar 14, 1883	
Signature of Rabbi		Name of Rabbi		Date of Service	
N. O. Yellow		N. O. Yellow		Mar 15, 1883	
Signature of Imam		Name of Imam		Date of Service	
P. Q. Purple		P. Q. Purple		Mar 16, 1883	
Signature of Minister		Name of Minister		Date of Service	
R. S. Green		R. S. Green		Mar 17, 1883	
Signature of Priest		Name of Priest		Date of Service	
T. U. Blue		T. U. Blue		Mar 18, 1883	
Signature of Rabbi		Name of Rabbi		Date of Service	
V. W. Yellow		V. W. Yellow		Mar 19, 1883	
Signature of Imam		Name of Imam		Date of Service	
X. Y. Purple		X. Y. Purple		Mar 20, 1883	
Signature of Minister		Name of Minister		Date of Service	
Z. A. Green		Z. A. Green		Mar 21, 1883	
Signature of Priest		Name of Priest		Date of Service	
B. C. Blue		B. C. Blue		Mar 22, 1883	
Signature of Rabbi		Name of Rabbi		Date of Service	
D. E. Yellow		D. E. Yellow		Mar 23, 1883	
Signature of Imam		Name of Imam		Date of Service	
F. G. Purple		F. G. Purple		Mar 24, 1883	
Signature of Minister		Name of Minister		Date of Service	
H. I. Green		H. I. Green		Mar 25, 1883	
Signature of Priest		Name of Priest		Date of Service	
J. K. Blue		J. K. Blue		Mar 26, 1883	
Signature of Rabbi		Name of Rabbi		Date of Service	
L. M. Yellow		L. M. Yellow		Mar 27, 1883	
Signature of Imam		Name of Imam		Date of Service	
N. O. Purple		N. O. Purple		Mar 28, 1883	
Signature of Minister		Name of Minister		Date of Service	
P. Q. Green		P. Q. Green		Mar 29, 1883	
Signature of Priest		Name of Priest		Date of Service	
R. S. Blue		R. S. Blue		Mar 30, 1883	
Signature of Rabbi		Name of Rabbi		Date of Service	
T. U. Yellow		T. U. Yellow		Mar 31, 1883	
Signature of Imam		Name of Imam		Date of Service	
V. W. Purple		V. W. Purple		Apr 1, 1883	
Signature of Minister		Name of Minister		Date of Service	
X. Y. Green		X. Y. Green		Apr 2, 1883	
Signature of Priest		Name of Priest		Date of Service	
Z. A. Blue		Z. A. Blue		Apr 3, 1883	
Signature of Rabbi		Name of Rabbi		Date of Service	
B. C. Yellow		B. C. Yellow		Apr 4, 1883	
Signature of Imam		Name of Imam		Date of Service	
D. E. Purple		D. E. Purple		Apr 5, 1883	
Signature of Minister		Name of Minister		Date of Service	
F. G. Green		F. G. Green		Apr 6, 1883	
Signature of Priest		Name of Priest		Date of Service	
H. I. Blue		H. I. Blue		Apr 7, 1883	
Signature of Rabbi		Name of Rabbi		Date of Service	
J. K. Yellow		J. K. Yellow		Apr 8, 1883	
Signature of Imam		Name of Imam		Date of Service	
L. M. Purple		L. M. Purple		Apr 9, 1883	
Signature of Minister		Name of Minister		Date of Service	
N. O. Green		N. O. Green		Apr 10, 1883	
Signature of Priest		Name of Priest		Date of Service	
P. Q. Blue		P. Q. Blue		Apr 11, 1883	
Signature of Rabbi		Name of Rabbi		Date of Service	
R. S. Yellow		R. S. Yellow		Apr 12, 1883	
Signature of Imam		Name of Imam		Date of Service	
T. U. Purple		T. U. Purple		Apr 13, 1883	
Signature of Minister		Name of Minister		Date of Service	
V. W. Green		V. W. Green		Apr 14, 1883	
Signature of Priest		Name of Priest		Date of Service	
X. Y. Blue		X. Y. Blue		Apr 15, 1883	
Signature of Rabbi		Name of Rabbi		Date of Service	
Z. A. Yellow		Z. A. Yellow		Apr 16, 1883	
Signature of Imam		Name of Imam		Date of Service	
B. C. Purple		B. C. Purple		Apr 17, 1883	
Signature of Minister		Name of Minister		Date of Service	
D. E. Green		D. E. Green		Apr 18, 1883	
Signature of Priest		Name of Priest		Date of Service	
F. G. Blue		F. G. Blue		Apr 19, 1883	
Signature of Rabbi		Name of Rabbi		Date of Service	
H. I. Yellow		H. I. Yellow		Apr 20, 1883	
Signature of Imam		Name of Imam		Date of Service	
J. K. Purple		J. K. Purple		Apr 21, 1883	
Signature of Minister		Name of Minister		Date of Service	
L. M. Green		L. M. Green		Apr 22, 1883	
Signature of Priest		Name of Priest		Date of Service	
N. O. Blue		N. O. Blue		Apr 23, 1883	
Signature of Rabbi		Name of Rabbi		Date of Service	
P. Q. Yellow		P. Q. Yellow		Apr 24, 1883	
Signature of Imam		Name of Imam		Date of Service	
R. S. Purple		R. S. Purple		Apr 25, 1883	
Signature of Minister		Name of Minister		Date of Service	
T. U. Green		T. U. Green		Apr 26, 1883	
Signature of Priest		Name of Priest		Date of Service	
V. W. Blue		V. W. Blue		Apr 27, 1883	
Signature of Rabbi		Name of Rabbi		Date of Service	
X. Y. Yellow		X. Y. Yellow		Apr 28, 1883	
Signature of Imam		Name of Imam		Date of Service	
Z. A. Purple		Z. A. Purple		Apr 29, 1883	
Signature of Minister		Name of Minister		Date of Service	
B. C. Green		B. C. Green		Apr 30, 1883	
Signature of Priest		Name of Priest		Date of Service	
D. E. Blue		D. E. Blue		May 1, 1883	
Signature of Rabbi		Name of Rabbi		Date of Service	
F. G. Yellow		F. G. Yellow		May 2, 1883	
Signature of Imam		Name of Imam		Date of Service	
H. I. Purple		H. I. Purple		May 3, 1883	
Signature of Minister		Name of Minister		Date of Service	
J. K. Green		J. K. Green		May 4, 1883	
Signature of Priest		Name of Priest		Date of Service	
L. M. Blue		L. M. Blue		May 5, 1883	
Signature of Rabbi		Name of Rabbi		Date of Service	
N. O. Yellow		N. O. Yellow		May 6, 1883	
Signature of Imam		Name of Imam		Date of Service	
P. Q. Purple		P. Q. Purple		May 7, 1883	
Signature of Minister		Name of Minister		Date of Service	
R. S. Green		R. S. Green		May 8, 1883	
Signature of Priest		Name of Priest		Date of Service	
T. U. Blue		T. U. Blue		May 9, 1883	
Signature of Rabbi		Name of Rabbi		Date of Service	
V. W. Yellow		V. W. Yellow		May 10, 1883	
Signature of Imam		Name of Imam		Date of Service	
X. Y. Purple		X. Y. Purple		May 11, 1883	
Signature of Minister		Name of Minister		Date of Service	
Z. A. Green		Z. A. Green		May 12, 1883	
Signature of Priest		Name of Priest		Date of Service	
B. C. Blue		B. C. Blue		May 13, 1883	
Signature of Rabbi		Name of Rabbi		Date of Service	
D. E. Yellow		D. E. Yellow		May 14, 1883	
Signature of Imam		Name of Imam		Date of Service	
F. G. Purple		F. G. Purple		May 15, 1883	
Signature of Minister		Name of Minister		Date of Service	
H. I. Green		H. I. Green		May 16, 1883	
Signature of Priest		Name of Priest		Date of Service	
J. K. Blue		J. K. Blue		May 17, 1883	
Signature of Rabbi		Name of Rabbi		Date of Service	
L. M. Yellow		L. M. Yellow		May 18, 1883	
Signature of Imam		Name of Imam		Date of Service	
N. O. Purple		N. O. Purple		May 19, 1883	
Signature of Minister		Name of Minister		Date of Service	
P. Q. Green		P. Q. Green		May 20, 1883	
Signature of Priest		Name of Priest		Date of Service	
R. S. Blue		R. S. Blue		May 21, 1883	
Signature of Rabbi		Name of Rabbi		Date of Service	
T. U. Yellow		T. U. Yellow		May 22, 1883	
Signature of Imam		Name of Imam		Date of Service	
V. W. Purple		V. W. Purple		May 23, 1883	
Signature of Minister		Name of Minister		Date of Service	
X. Y. Green		X. Y. Green		May 24, 1883	
Signature of Priest		Name of Priest		Date of Service	
Z. A. Blue		Z. A. Blue		May 25, 1883	
Signature of Rabbi		Name of Rabbi		Date of Service	
B. C. Yellow		B. C. Yellow		May 26, 1883	
Signature of Imam		Name of Imam		Date of Service	
D. E. Purple		D. E. Purple		May 27, 1883	
Signature of Minister		Name of Minister		Date of Service	
F. G. Green		F. G. Green		May 28, 1883	
Signature of Priest		Name of Priest		Date of Service	
H. I. Blue		H. I. Blue		May 29, 1883	
Signature of Rabbi		Name of Rabbi		Date of Service	
J. K. Yellow		J. K. Yellow		May 30, 1883	
Signature of Imam		Name of Imam		Date of Service	
L. M. Purple		L. M. Purple		May 31, 1883	
Signature of Minister		Name of Minister		Date of Service	
N. O. Green		N. O. Green		Jun 1, 1883	
Signature of Priest		Name of Priest		Date of Service	
P. Q. Blue		P. Q. Blue		Jun 2, 1883	
Signature of Rabbi		Name of Rabbi		Date of Service	
R. S. Yellow		R. S. Yellow		Jun 3, 1883	
Signature of Imam		Name of Imam		Date of Service	
T. U. Purple					

## 7830 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL WESTMINSTER</u>				c. LENGTH OF STAY IN 1b <u>30 YR</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RD 5</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>INEZ CULLISON HORINE</u>				4. DATE OF DEATH Month Day Year <u>JULY 23 1958</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 21, 1909</u>	9. AGE (In years, last birthday) <u>48</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>CHESTER CULLISON</u>				14. MOTHER'S MAIDEN NAME <u>NANNIE GREEN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>215-20-8335</u>		17. INFORMANT <u>RANDOLPH A. HORINE</u> Address <u>RD 5</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>Coronary Sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Obesity &amp; mild hypertension</u> (c) <u>Obesity &amp; mild hypertension</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Several hrs.</u> <u>Several yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>July 19, 1958</u> to <u>July 23, 1958</u> , that I last saw the deceased alive on <u>July 19, 1958</u> , and that death occurred at <u>USA</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. Glenn Speicher</u>				ADDRESS (Street, city or town, state) <u>Westminster Md</u>			
PHYSICIAN'S NAME (Type) <u>W. Glenn Speicher</u>				DATE SIGNED <u>7/24/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7-26-1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MEADOW BRANCH CEM. WESTMINSTER</u>		22d. LOCATION (City, town, or county) (State) <u>MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>David A. Barbard</u>				ADDRESS <u>Westminster Md.</u>		24a. REC'D BY REGISTRAR <u>Jul 28 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>W. Glenn Speicher</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 7831 CERTIFICATE OF DEATH

07827

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Cecil</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Eldersburg</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i> <i>3701-4</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Grand View Nursing Home</i>				d. STREET ADDRESS <i>2537 Woodbrook Ave.</i>			
3. NAME OF DECEASED (Type or print) First <i>MARIE</i> Middle <i>D.</i> Last <i>HORNING</i>				4. DATE OF DEATH Month <i>July</i> Day <i>28</i> Year <i>19 58</i>			
5. SEX <i>female</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Feb. 9, 1897</i>	
9. AGE (In years last birthday) <i>61</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Bookkeeper (Rtd)</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Wholesale Jewelry</i>		11. BIRTHPLACE (State or foreign country) <i>Md.</i>	
13. FATHER'S NAME <i>Wilhelm Hornung</i>				14. MOTHER'S MAIDEN NAME <i>Katherine Mueller</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>				16. SOCIAL SECURITY NO.		17. INFORMANT Address <i>Mr. Henry P. Hornung - 3721 Marmon Ave.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastasis from Carcinoma</i> 170x DUE TO <i>Carcinoma of the Breast</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <i>Benign hyperplasia</i> (c) <i>Oct. 21 1952</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>Oct. 21, 1952</i> , to <i>July 28, 1958</i> , that I last saw the deceased alive on <i>July 28, 1958</i> , and that death occurred at <i>2:30 P.M.</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>W.A. D. RUBY</i>				ADDRESS (Street, city or town, state) DATE SIGNED <i>817 Medical Art Bldg. Baltimore 1 Md. 7/28/58</i>			
PHYSICIAN'S NAME (Type) <i>W.A. D. RUBY</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7/30/58</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Loudon Park Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Balto., Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. J. Dickner &amp; Sons - Balto. 17, Md.</i>				24a. REC'D BY REGISTRAR DATE <i>JUL 31 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Wm. J. Dickner</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

154

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7832

CERTIFICATE OF DEATH

Reg. Dist. No.

07828

1. PLACE OF DEATH o. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville (Rural)</b>				c. LENGTH OF STAY IN 1b <b>1 y. 7 m. 20 d.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>123 Greenmount Avenue</b>			
3. NAME OF DECEASED (Type or print) First <b>Anna</b> Middle <b>Matilda</b> Last <b>Jennings</b>				4. DATE OF DEATH Month <b>July</b> Day <b>28</b> Year <b>1958</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>December 19, 1880</b>	
9. AGE (In years last birthday) <b>77</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Charles Edward Fry</b>				14. MOTHER'S MAIDEN NAME <b>Mary Margaret Goodman</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Springfield State Hospital Record</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute + Chronic Myocardial Infarction</b> DUE TO <b>Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of colon</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>years</b> <b>Months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic brain syndrome associated with circulatory disturbance, with cerebral arteriosclerosis, with psychotic reaction.</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>December 8, 1956</b> , to <b>July 28, 1958</b> , that I last saw the deceased alive on <b>July 28, 1958</b> , and that death occurred at <b>10:30 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Elizabeth Knopp</b>				M.D. <b>Springfield State Hospital</b>		DATE SIGNED <b>7/29/58</b>	
PHYSICIAN'S NAME (Type) <b>Elizabeth Knopp, M. D.</b>				<b>Sykesville, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>7-31-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Episcopal Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Brownsville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Minnich Funeral Home, Hagerstown, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>III 31 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Leach</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

07829

7833

Item 1 Film 6231 7-21-58 et

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>CARROLL</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Sykesville</b> c. LENGTH OF STAY IN 1b <b>-----</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital Admitting Office</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore Co.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk-22</b> d. STREET ADDRESS <b>2915 Cornwall Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ANNIE</b> Middle <b>MARIA</b> Last <b>KILPATRICK</b>		4. DATE OF DEATH Month <b>7/</b> Day <b>11</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/21/64</b>
9. AGE (In years last birthday) <b>93</b> yrs.		10. IF UNDER 1 YEAR: Months <b>0</b> Days <b>35</b> Hours <b>3</b> Min. <b>2</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	
11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George Bradshaw</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Charles C. Kilpatrick,</b>		<b>7319 Betz Avenue Baltimore-19, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Arteriosclerotic cardiovascular disease with</b> (a), stating the underlying cause last. DUE TO <b>decompensation.</b> (c) <b>-----</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b> <b>Years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>-----</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>-----</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>-----</b> a. m. <b>-----</b> p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-----</b>	20f. (City or town) <b>-----</b> (County) <b>-----</b> (State) <b>-----</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>James T. Marsh</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>James T. Marsh, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <b>7/11/58</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7/12/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Greenhill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Martinsburg, West Virginia</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook - Blight, Inc</b>		24a. REC'D BY REGISTRAR <b>7/14/58</b>	
ADDRESS <b>6009 Harford Road</b>		24b. REGISTRAR'S SIGNATURE <b>W. Cook</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 must be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use of the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

07830

Reg. Dist. No.

7834

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Taneytown</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Rural Taneytown</u>	
		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Roland</u> Middle <u>William</u> Last <u>Koons</u>		4. DATE OF DEATH Month <u>July</u> Day <u>1</u> Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 7, 1893</u>
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>J. Addison Koons</u>		14. MOTHER'S MAIDEN NAME <u>Emma Jane Williams</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WW1</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-36-9432</u>	
17. INFORMANT <u>Mrs. Carrie Koons, Taneytown, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Basal Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Date nature of injury in Part I or Port II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6-30-</u> , 19 <u>58</u> , to <u>7-1-</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>7-1-</u> , 19 <u>58</u> , and that death occurred at <u>7:30</u> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Union Bridge Md-7-1-58</u> ACTUAL SIGNATURE <u>J. N. Legg</u> M.D. <u>Union Bridge Md-7-1-58</u> PHYSICIAN'S NAME (Type) <u>T. H. LEGG MD</u> <u>Union Bridge Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/3/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Keysville Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Keysville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Microph C. Fuss</u> C.O. Fuss & Son		24a. REC'D BY REGISTRAR DATE <u>JUL 3 '58</u>	
ADDRESS <u>Taneytown, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Alb. Leach</u>	



## CERTIFICATE OF DEATH

7835

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>3 mos. 26 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Margaret</b> Middle <b>Louise</b> Last <b>Barwick LAUMANN</b>		4. DATE OF DEATH Month <b>July</b> Day <b>17</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 2, 1894</b>
9. AGE (In years last birthday) <b>63</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Barwick</b>		14. MOTHER'S MAIDEN NAME <b>Anne Phipps</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Springfield Hospital Records</b>		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho Pneumonia</b> 491X not DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>Hypertensive Cardiovascular disease</b> (c) <b>Generalized Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. assoc. with circ. dist. other than cerebral arteriosclerosis, with psychotic reaction.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>

20a. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20d. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <b>March 21, 1958</b> , to <b>July 17, 1958</b> , that I last saw the deceased alive on <b>July 17, 1958</b> , and that death occurred at <b>11:40 A.M.</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>7/17/58</b>				
ACTUAL SIGNATURE <b>Agustin del Campo</b> M.D.		PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b> <b>Sykesville, Maryland.</b>				

22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>JULY 21, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>SCHWARTZ CEMETERY</b>	22d. LOCATION (City, town, or county) (State) <b>BALTIMORE MARYLAND</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Burns Son's</b>		24. REC'D BY REGISTRAR <b>Jul 21 '58</b>	
ADDRESS <b>Bowson 4, Ind.</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Couch</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director. Page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

1935

<p>1. Name of deceased: <u>John Doe</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>Jan 1, 1900</u></p>		<p>4. Place of birth: <u>City, State</u></p>	
<p>5. Date of death: <u>Dec 31, 1935</u></p>		<p>6. Place of death: <u>City, State</u></p>	
<p>7. Cause of death: <u>Heart Disease</u></p>		<p>8. Manner of death: <u>Natural</u></p>	
<p>9. Signature of physician: <u>[Signature]</u></p>		<p>10. Signature of registrar: <u>[Signature]</u></p>	
<p>11. Name of informant: <u>John Doe</u></p>		<p>12. Address of informant: <u>City, State</u></p>	
<p>13. Name of informant: <u>John Doe</u></p>		<p>14. Address of informant: <u>City, State</u></p>	
<p>15. Name of informant: <u>John Doe</u></p>		<p>16. Address of informant: <u>City, State</u></p>	
<p>17. Name of informant: <u>John Doe</u></p>		<p>18. Address of informant: <u>City, State</u></p>	
<p>19. Name of informant: <u>John Doe</u></p>		<p>20. Address of informant: <u>City, State</u></p>	
<p>21. Name of informant: <u>John Doe</u></p>		<p>22. Address of informant: <u>City, State</u></p>	
<p>23. Name of informant: <u>John Doe</u></p>		<p>24. Address of informant: <u>City, State</u></p>	
<p>25. Name of informant: <u>John Doe</u></p>		<p>26. Address of informant: <u>City, State</u></p>	
<p>27. Name of informant: <u>John Doe</u></p>		<p>28. Address of informant: <u>City, State</u></p>	
<p>29. Name of informant: <u>John Doe</u></p>		<p>30. Address of informant: <u>City, State</u></p>	
<p>31. Name of informant: <u>John Doe</u></p>		<p>32. Address of informant: <u>City, State</u></p>	
<p>33. Name of informant: <u>John Doe</u></p>		<p>34. Address of informant: <u>City, State</u></p>	
<p>35. Name of informant: <u>John Doe</u></p>		<p>36. Address of informant: <u>City, State</u></p>	
<p>37. Name of informant: <u>John Doe</u></p>		<p>38. Address of informant: <u>City, State</u></p>	
<p>39. Name of informant: <u>John Doe</u></p>		<p>40. Address of informant: <u>City, State</u></p>	
<p>41. Name of informant: <u>John Doe</u></p>		<p>42. Address of informant: <u>City, State</u></p>	
<p>43. Name of informant: <u>John Doe</u></p>		<p>44. Address of informant: <u>City, State</u></p>	
<p>45. Name of informant: <u>John Doe</u></p>		<p>46. Address of informant: <u>City, State</u></p>	
<p>47. Name of informant: <u>John Doe</u></p>		<p>48. Address of informant: <u>City, State</u></p>	
<p>49. Name of informant: <u>John Doe</u></p>		<p>50. Address of informant: <u>City, State</u></p>	
<p>51. Name of informant: <u>John Doe</u></p>		<p>52. Address of informant: <u>City, State</u></p>	
<p>53. Name of informant: <u>John Doe</u></p>		<p>54. Address of informant: <u>City, State</u></p>	
<p>55. Name of informant: <u>John Doe</u></p>		<p>56. Address of informant: <u>City, State</u></p>	
<p>57. Name of informant: <u>John Doe</u></p>		<p>58. Address of informant: <u>City, State</u></p>	
<p>59. Name of informant: <u>John Doe</u></p>		<p>60. Address of informant: <u>City, State</u></p>	
<p>61. Name of informant: <u>John Doe</u></p>		<p>62. Address of informant: <u>City, State</u></p>	
<p>63. Name of informant: <u>John Doe</u></p>		<p>64. Address of informant: <u>City, State</u></p>	
<p>65. Name of informant: <u>John Doe</u></p>		<p>66. Address of informant: <u>City, State</u></p>	
<p>67. Name of informant: <u>John Doe</u></p>		<p>68. Address of informant: <u>City, State</u></p>	
<p>69. Name of informant: <u>John Doe</u></p>		<p>70. Address of informant: <u>City, State</u></p>	
<p>71. Name of informant: <u>John Doe</u></p>		<p>72. Address of informant: <u>City, State</u></p>	
<p>73. Name of informant: <u>John Doe</u></p>		<p>74. Address of informant: <u>City, State</u></p>	
<p>75. Name of informant: <u>John Doe</u></p>		<p>76. Address of informant: <u>City, State</u></p>	
<p>77. Name of informant: <u>John Doe</u></p>		<p>78. Address of informant: <u>City, State</u></p>	
<p>79. Name of informant: <u>John Doe</u></p>		<p>80. Address of informant: <u>City, State</u></p>	
<p>81. Name of informant: <u>John Doe</u></p>		<p>82. Address of informant: <u>City, State</u></p>	
<p>83. Name of informant: <u>John Doe</u></p>		<p>84. Address of informant: <u>City, State</u></p>	
<p>85. Name of informant: <u>John Doe</u></p>		<p>86. Address of informant: <u>City, State</u></p>	
<p>87. Name of informant: <u>John Doe</u></p>		<p>88. Address of informant: <u>City, State</u></p>	
<p>89. Name of informant: <u>John Doe</u></p>		<p>90. Address of informant: <u>City, State</u></p>	
<p>91. Name of informant: <u>John Doe</u></p>		<p>92. Address of informant: <u>City, State</u></p>	
<p>93. Name of informant: <u>John Doe</u></p>		<p>94. Address of informant: <u>City, State</u></p>	
<p>95. Name of informant: <u>John Doe</u></p>		<p>96. Address of informant: <u>City, State</u></p>	
<p>97. Name of informant: <u>John Doe</u></p>		<p>98. Address of informant: <u>City, State</u></p>	
<p>99. Name of informant: <u>John Doe</u></p>		<p>100. Address of informant: <u>City, State</u></p>	

4

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

07832

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>1647 E. North Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>Kathleen</b> Middle <b>Jean</b> Last <b>McDonnell</b>		4. DATE OF DEATH Month <b>July</b> Day <b>20</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 19, 1900</b>
9. AGE (In years last birthday) <b>58</b> yrs.		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Massachusetts</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Michael McDonnell</b>		14. MOTHER'S MAIDEN NAME <b>Mary Kelly</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Springfield State Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriolar nephrosclerosis</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Involuntional psychotic reaction.</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>Weeks</b> <b>Years.</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 30, 1958</b> , to <b>July 20, 1958</b> , that I last saw the deceased alive on <b>July 20, 1958</b> , and that death occurred at <b>9:40 P</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Edmund Lusthaus</b> M.D.		ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>7/21/58</b>	
PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus, M.D.</b>		<b>Sykesville, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/24/1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Eusworth Ammons</b>		24a. REC'D BY REGISTRAR <b>JUL 28 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>W. Leach</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH		PLACE OF DEATH	
TIME OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		DISEASE OR INJURY	
AGE		SEX	
RACE		RELIGION	
BIRTH DATE		BIRTH PLACE	
EDUCATION		OCCUPATION	
MARRIAGE		PREVIOUS ILLNESS	
TREATMENT		HISTORY	
FAMILY HISTORY		SOCIAL HISTORY	
PHYSICAL EXAMINATION		LABORATORY TESTS	
PATHOLOGICAL FINDINGS		MICROSCOPIC FINDINGS	
GROSS FINDINGS		HISTOLOGICAL FINDINGS	
IMPRESSION		REMARKS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE OF SIGNATURE		PLACE OF SIGNATURE	

7836

## CERTIFICATE OF DEATH

07833

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>York</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hannover Pa</u> 75x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Long View Nursing Home</u>		d. STREET ADDRESS <u>109 N. Franklin St</u>	
3. NAME OF DECEASED (Type or print) First <u>Heber</u> Middle <u>Michael</u> Last <u>Michael</u>		4. DATE OF DEATH Month <u>July</u> Day <u>1</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 7, 1872</u> 86 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Legion</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mens Clothes</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Michael</u>		14. MOTHER'S MAIDEN NAME <u>Angeline Albright</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>S. Donald Michael</u>		Address <u>Hannover Pa</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diabetic Laurence of Pitts &amp; left foot</u> 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes Mellitus</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Generalized Arteriosclerosis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April 12, 1958</u> to <u>July 1, 1958</u> , that I last saw the deceased alive on <u>July 1, 1958</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph E. Bush</u> M.D.		ADDRESS (Street, city or town, state) <u>Hampstead, Maryland</u>	
PHYSICIAN'S NAME (Type) <u>Joseph E. Bush MD</u>		DATE SIGNED <u>7/1/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7-4-1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Hannover Pa</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Dennis R. D. Wetzel</u> ADDRESS <u>549 Carlisle St, Hannover, Pa</u>		24a. REC'D BY REGISTRAR <u>—</u> DATE <u>JUL 7 '58</u>	24b. REGISTRAR'S SIGNATURE <u>—</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## 7837 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>4 mos. 24 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Lola May Sherman MORGRET</b>		4. DATE OF DEATH Month Day Year <b>July 31, 19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 18, 1889 '88</b>
9. AGE (In years last birthday) yrs. <b>68</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown Thomas Sherman</b>		14. MOTHER'S MAIDEN NAME <b>Unknown Mary Jane Everets</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Springfield Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Rheumatic valvulitis inactive (with deformity 410X Not due to mitral valve)</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. assoc. with senile brain disease with psychotic reaction. Paget's disease of bone.</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 7, 19 58</b> to <b>July 31, 19 58</b> , that I last saw the deceased alive on <b>July 30, 19 58</b> , and that death occurred at <b>5:20A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Agustin del Campo</b> M.D.		ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b>	
PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>		DATE SIGNED <b>7/31/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-4-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Johns Lutheran</b>		22d. LOCATION (City, town, or county) (State) <b>Pfieffers Corner, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. C. Higginbotham, Ellicott City, Md</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 4 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>W. C. Higginbotham</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



7838

CERTIFICATE OF DEATH

Reg. Dist. No. 07835

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>7mos. 21days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Mabel Edith Finch</b> First Middle Last		4. DATE OF DEATH <b>July 7, 1958</b> Month Day Year	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 30, 1872</b>
9. AGE (In years last birthday) <b>86</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Stenographer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Indiana</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Isaac B. Finch</b>		14. MOTHER'S MAIDEN NAME <b>Eliza Bare</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Springfield Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>491X</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. assoc. with circ. dist., with cerebral arteriosclerosis with psychotic reaction.</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from <b>Nov. 16, 1958</b> to <b>July 7, 1958</b> , that I last saw the deceased alive on <b>July 7, 1958</b> , and that death occurred at <b>7:25PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Edmund Lusthaus</b> M.D. <b>Springfield Hospital</b> <b>7/8/58</b> PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus, M.D.</b> <b>Sykesville, Md.</b> 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 22b. DATE THEREOF <b>July 11, 1958</b> 22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore</b> 22d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b> 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Wm. Cook, Inc. 1217 St. Paul St.</b> 24a. REC'D BY REGISTRAR <b>JUL 10 '58</b> 24b. REGISTRAR'S SIGNATURE <b>Alfred Smith</b>			



1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7839 CERTIFICATE OF DEATH

Reg. Dist. No. 07836

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>10 mos. 9 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> 1556.2	
d. STREET ADDRESS <b>9628 Dilston Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Helen</b> Middle <b>Hard</b> Last <b>Nelson</b>		4. DATE OF DEATH Month <b>July</b> Day <b>13</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 10, 1880</b>
9. AGE (In years last birthday) <b>77</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jacob Hard</b>		14. MOTHER'S MAIDEN NAME <b>Isabel Dunn</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>unk</b>	
17. INFORMANT <b>Springfield Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. assoc. with dist. of metabolism, growth or nutrition, with senile brain disease with psychotic reaction.</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from <b>September 4, 19 57</b> , to <b>July 13, 19 58</b> , that I last saw the deceased alive on <b>July 13, 19 58</b> , and that death occurred at <b>4:53 P</b> M, from the causes and on the date stated above. ACTUAL SIGNATURE <b>Edmund Lusthaus</b> ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>7/14/58</b> PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus, M.B.</b> <b>Sykesville, Maryland</b> 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Transplantation</b> 22b. DATE THEREOF <b>7-21-58</b> 22c. NAME OF CEMETERY OR CREMATORY <b>Sunnyside Memorial Park</b> 22d. LOCATION (City, town, or county) (State) <b>Long Beach, Cal.</b> 23. FUNERAL DIRECTOR'S SIGNATURE <b>Kathleen H. Haight</b> ADDRESS <b>Sykesville, Md.</b> 24a. REC'D BY REGISTRAR <b>W. Beach</b> 24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

7840

Reg. Dist. No. 07837

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>5 yrs. lmo. 13 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Frank</b> Middle <b>NOYA, Sr.</b> Last <b>NOYA, Sr.</b>		4. DATE OF DEATH Month <b>July</b> Day <b>17</b> Year <b>58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 27, 1875</b>
9. AGE (In years last birthday) <b>83</b> yrs.		10. IF UNDER 1 YEAR: Months <b>3</b> Days <b>01</b> Hours <b>4</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Longshoreman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Spain</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Ramon Noya</b>		14. MOTHER'S MAIDEN NAME <b>Josephine Naveira</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT Address <b>Springfield Hospital Records.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> 491X <b>Arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Generalized arteriosclerosis</b> (b) <b>Generalized arteriosclerosis</b> (c) <b>Generalized arteriosclerosis</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. with senile brain disease with psychotic reaction.</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 7, 1955</b> to <b>July 17, 1958</b> that I last saw the deceased alive on <b>July 16, 1958</b> and that death occurred at <b>12:05 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Agustin del Campo</b> M.D.		ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b>	
DATE SIGNED <b>7/17/58</b>			
PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>		<b>Sykesville, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7/21/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Evergreen</b>	22d. LOCATION (City, town, or county) (State) <b>Essex Co. N.J.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck, Inc.</b>		ADDRESS <b>5305 Harford Rd.</b>	
24a. REC'D BY REGISTRAR <b>JUL 21 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. J. Ruck</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the funeral director. After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



7841

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Henryton</b>		c. LENGTH OF STAY IN 1b <b>249 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Henryton State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Emory</b> Middle <b>Richard</b> Last <b>Offer</b>		4. DATE OF DEATH Month <b>July</b> Day <b>20</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-19-1898</b>
9. AGE (In years last birthday) <b>60</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>	
11. BIRTHPLACE (State or foreign country) <b>Churchton, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A?</b>	
13. FATHER'S NAME <b>Richard Offer</b>		14. MOTHER'S MAIDEN NAME <b>Mary Brooks</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT Address <b>Florida Offer - Churchton, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Far advanced pulmonary Tbc. left with pleurisy</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Suspected tumor</b> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>November 13, 1957</b> , to <b>July 20, 1958</b> , that I last saw the deceased alive on <b>July 20, 1958</b> , and that death occurred at <b>11:45 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>E. M. Maculans M.D.</b>		ADDRESS (Street, city or town, state) <b>Henryton, Maryland</b> DATE SIGNED <b>7-20-58</b>	
PHYSICIAN'S NAME (Type) <b>E. M. Maculans, M. D.</b>		<b>Henryton State Hospital</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7-24-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Matthew's Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>St. Mary's, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Reese #2. 108 H. H. Washington St.</b>		24a. REC'D BY REGISTRAR <b>Jul 25 58</b>	24b. REGISTRAR'S SIGNATURE <b>John Reese</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

005107

07839

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>CARROLL</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>CARROLL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WESTMINSTER</b>		c. LENGTH OF STAY IN TB <b>81 YRS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>49 CHURCH</b>		e. STREET ADDRESS <b>49 CHURCH</b>	
3. NAME OF DECEASED (Type or print) <b>SARAH PAULINE</b> First Middle Last		4. DATE OF DEATH <b>JULY 26</b> Month Day Year	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 29 1877</b> 9. AGE (In years last birthday) <b>81</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MD.</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>ROBERT E. FRIZZELL</b>		14. MOTHER'S MAIDEN NAME <b>MARY J. BELL</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>ROTH E. OHLER</b> Address <b>49 CHURCH WESTMINSTER MD.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE</b> DUE TO <b>ASCVD DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ASCVD DISEASE</b> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH <b>8 days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7-18-58</b> to <b>7-26</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>7-26</b> , 19 <b>58</b> , and that death occurred at <b>5:30 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James J. Moran</b> M.D.		ADDRESS (Street, city or town, state) <b>105 E MAIN</b> DATE SIGNED <b>7/28/58</b>	
PHYSICIAN'S NAME (Type) <b>JAMES T. MARSH</b>		<b>WESTMINSTER MD</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>JULY 30 / 58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>WESTMINSTER CEM.</b>	22d. LOCATION (City, town, or county) (State) <b>WESTMINSTER MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>David G. Bankard</b> ADDRESS <b>Westminster, Md.</b>		24a. REC'D BY REGISTRAR <b>Aug 4 '58</b> 24b. REGISTRAR'S SIGNATURE <b>W. H. Church</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

07840

7842

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Sykesville</b> c. LENGTH OF STAY IN 1b <b>3yrs.7mos.20days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>---</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore City</b> d. STREET ADDRESS <b>3120 Keswick Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Michael</b> Middle <b>-</b> Last <b>O'SHEA</b>		4. DATE OF DEATH Month <b>July</b> Day <b>29</b> Year <b>19 58</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>unknown</b>
9. AGE (In years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR <b>---</b> Months <b>---</b> Days <b>---</b> Hours <b>---</b> Min. <b>---</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
13. FATHER'S NAME <b>unknown</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>220-05-3129</b>	
17. INFORMANT <b>Records of Springfield State Hospital</b>		Address <b>Sykesville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> <b>420.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Suppurative nephritis</b> DUE TO (c) <b>---</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic brain syndrome assoc. with circulatory disturbance, with cerebral arteriosclerosis, with psychotic reaction.</b> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>---</b> p. m. <b>---</b> 19 <b>58</b>	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>---</b>	
20f. (City or town) <b>---</b> (County) <b>---</b> (State) <b>---</b>		21. I certify that I attended the deceased from <b>Aug. 1955</b> , to <b>July 29, 1958</b> , that I last saw the deceased alive on <b>July 29, 1958</b> , and that death occurred at <b>10:10AM</b> , from the causes and on the date stated above.	
ACTUAL SIGNATURE <b>Walter Knopp</b> M.D. <b>Springfield State Hospital</b>		DATE SIGNED <b>7/29/58</b>	
PHYSICIAN'S NAME (Type) <b>Walter Knopp, M. D.</b>		<b>Sykesville, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug. 8/1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Pk.</b>		22d. LOCATION (City, town, or county) <b>Baltimore Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Frank X. Seitz</b>		24a. REC'D BY REGISTRAR <b>JUL 31 '58</b>	
ADDRESS <b>814 W 36th St</b>		24b. REGISTRAR'S SIGNATURE <b>W. Knopp</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



7843

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Henryton</b>				c. LENGTH OF STAY IN 1b <b>95 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Henryton State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Martha</b> Middle <b>Minerva</b> Last <b>Parker</b>				4. DATE OF DEATH Month <b>July</b> Day <b>13</b> Year <b>1958</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 3, 1901</b>	
9. AGE (In years last birthday) <b>57</b> yrs.		IF UNDER 1 YEAR Months <b>57</b> Days <b>13</b> Hours <b>19</b> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Benjamin Brown</b>				14. MOTHER'S MAIDEN NAME <b>Rosie Burgess</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Martha M. Parker - Patient</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Insufficiency</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Far advanced bilateral cavitory pulmonary Tbc.</b> DUE TO (c) <b>Diabetes Mellitus</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>262X</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 9</b> , 19 <b>58</b> , to <b>July 13</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>July 13</b> , 19 <b>58</b> , and that death occurred at <b>11 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>E. M. Maculans, M.D.</b>		ADDRESS (Street, city or town, state) <b>Henryton, Maryland</b>				DATE SIGNED <b>7-13-58</b>	
PHYSICIAN'S NAME (Type) <b>Edgars M. Maculans, M. D.</b>		HOSPITAL (Name and address) <b>Henryton State Hospital</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-19-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Adams Chapel</b>		22d. LOCATION (City, town, or county) (State) <b>Bayard, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Reese, Jr.</b>		ADDRESS <b>Annapolis, Md.</b>		24a. REC'D BY REGISTRAR <b>JUL 18 1958</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. H. H.</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

7-25-50

DATE OF DEATH

DECEASED

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W. J. ...

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## 7844

Item 7 Film G231.7/18/58 pg 1

# CERTIFICATE OF DEATH

Reg. Dist. No.

07842

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Carroll</u> <span style="float: right;"><b>MARYLAND</b></span>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Baltimore</u></span>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville - Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="float: right;">✓</span> <u>Baltimore</u> <span style="float: right;"><u>3401-4</u></span>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>		d. STREET ADDRESS <u>2810 Guilford Avenue</u>	
<b>3. NAME OF DECEASED</b> (Type or print) <span style="float: right;">First Middle Last</span> <u>Margaret Engle Prather</u>		<b>4. DATE OF DEATH</b> Month <u>July</u> Day <u>11</u> Year <u>1958</u>	
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>November 23, 1858</u>
		<b>9. AGE</b> (In years last birthday) <u>99</u> yrs.	<b>IF UNDER 1 YEAR</b> <input type="checkbox"/> <b>IF UNDER 24 HRS.</b> <input type="checkbox"/>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>None</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>None</u>	<b>11. BIRTHPLACE</b> (State or foreign country) <u>OHIO</u>
<b>13. FATHER'S NAME</b> <u>Unknown</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Unknown</u>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>None</u>	
		<b>17. INFORMANT</b> <u>Springfield Hospital Record</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bronchopneumonia</u> DUE TO (c) <u>Myocardial insufficiency</u>			<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>hours</u> <u>days</u> <u>months</u>
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <u>Chronic Brain Syndrome associated with disturbance of growth, metabolism or nutrition, with psychotic reaction.</u>			<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>491X</u>	
<b>20c. TIME OF INJURY</b> Hour <u>o. p.</u> Month <u>19</u> Day <u>19</u> Year <u>1958</u>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> (County) (State)
<b>21. I certify that I attended the deceased from</b> <u>July 1,</u> 19 <u>57</u> , <b>to</b> <u>July 11,</u> 19 <u>58</u> , <b>that I last saw the deceased alive on</b> <u>July 10,</u> 19 <u>58</u> , <b>and that death occurred at</b> <u>2:00 AM</u> , <b>from the causes and on the date stated above.</b> <b>ADDRESS</b> (Street, city or town, state) <u>Springfield State Hospital</u> <b>DATE SIGNED</b> <u>7-11-58</u>			
<b>ACTUAL SIGNATURE</b> <u>Rita S. Glehn</u> <b>M.D.</b> <u>Springfield State Hospital</u>			
<b>PHYSICIAN'S NAME (Type)</b> <u>Rita S. Glehn, M. D.</u> <u>Sykesville, Maryland</u>			
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>	<b>22b. DATE THEREOF</b> <u>July 14, 1958</u>	<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Loudon Park</u>	<b>22d. LOCATION</b> (City, town, or county) (State) <u>Baltimore Md.</u>
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Wm. Cook, Inc. 1217 St. Paul St.</u>		<b>24a. REC'D BY REGISTRAR</b> DATE <u>JUL 14 '58</u>	<b>24b. REGISTRAR'S SIGNATURE</b> <u>W. H. Leach</u>



# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

REG. NO. 10

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH May 19, 1928		5. PLACE OF BIRTH Jackson, Tennessee	
6. OCCUPATION Attorney		7. MARITAL STATUS Single		8. COLOR White		9. HEIGHT 5' 10"		10. WEIGHT 170	
11. CAUSE OF DEATH Suicide		12. MANNER OF DEATH Homicide		13. PLACE OF DEATH Baltimore, Maryland		14. DATE OF DEATH May 24, 1968		15. TIME OF DEATH 10:00 AM	
16. SIGNATURE OF DECEASED James Earl Ray		17. SIGNATURE OF NEXT OF KIN John D. Ray		18. SIGNATURE OF PHYSICIAN Dr. J. Edgar Hoover		19. SIGNATURE OF CORONER John D. Ray		20. SIGNATURE OF JURY John D. Ray	
21. SIGNATURE OF WITNESS John D. Ray		22. SIGNATURE OF WITNESS John D. Ray		23. SIGNATURE OF WITNESS John D. Ray		24. SIGNATURE OF WITNESS John D. Ray		25. SIGNATURE OF WITNESS John D. Ray	

RECEIVED MAY 24 1968  
BALTIMORE, MARYLAND  
STATE DEPARTMENT OF HEALTH

7845

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Carroll</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>HAMPSTEAD</i>		c. LENGTH OF STAY IN 1b <i>12 yrs.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>202 S. Main St</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>x HAMPSTEAD Maryland</i>	
f. STREET ADDRESS <i>202 S MAIN</i>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>SADIE</i> First Middle Last		4. DATE OF DEATH <i>July 29 1958</i> Month Day Year	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 27 1867</i> 9. AGE (In years, lost birthday) <i>91</i> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>George W. Wilhelm</i>	
14. MOTHER'S MAIDEN NAME <i>Ruth Brown</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT <i>Mrs Maude Wobbelking</i> Address <i>Hampstead Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic myocarditis</i> DUE TO <i>Arteriosclerotic Cardiovascular disease</i> DUE TO <i>?</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <i>?</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>903.0 fracture 2 left - ribs</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i>x</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Fell on Living Room Floor.</i>	
20c. TIME OF INJURY Month, Day, Year <i>6-1-1958</i> Hour <i>6-1-1958</i> a. p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>	20f. (City or town) <i>Hampstead</i> (County) <i>Carroll</i> (State) <i>Md</i>
21. I certify that I attended the deceased from <i>June 1, 1958</i> to <i>July 29, 1958</i> , that I last saw the deceased alive on <i>July 28, 1958</i> , and that death occurred at <i>7:29 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Joseph E. Bush</i> M.D.		ADDRESS (Street, city or town, state) <i>Hampstead Md</i> DATE SIGNED <i>7/29/58</i>	
PHYSICIAN'S NAME (Type) <i>Joseph E. Bush MD</i>		<i>HAMPSTEAD Maryland</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Aug 15-8</i>	22c. NAME OF CEMETERY OR CREMATORY <i>St Pauls</i>	22d. LOCATION (City, town, or county) (State) <i>Balto Co Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edwin Shopton</i> ADDRESS <i>Hampstead Md</i>		24a. REC'D BY REGISTRAR <i>JUL 31 '58</i>	24b. REGISTRAR'S SIGNATURE <i>W. Beach</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.



# 1 M 15 1 0 VS A15 (4) 15M 10/57 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. 1 M 15 1 0 VS A15 (4) 15M 10/57 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## 7846 CERTIFICATE OF DEATH

Reg. Dist. No. 07844

1. PLACE OF DEATH o. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>20yrs. 6mos. 14days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>6707 Alleghany Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Etha</b> Middle <b>B.</b> Last <b>Roach</b>		4. DATE OF DEATH Month <b>July</b> Day <b>15</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1884</b>
9. AGE (In years last birthday) <b>74</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>School teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Public School</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>unk -</b>	
17. INFORMANT <b>Springfield Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>491X</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <b>Arteriosclerotic heart disease.</b> (c) <b>1001X</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>Days</b> <b>Years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Schizophrenic reaction, paranoid type.</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>October 20, 1954</b> to <b>July 15, 1958</b> , that I last saw the deceased alive on <b>July 14, 1958</b> , and that death occurred at <b>1:30A M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Edmund Lusthaus</b>		DATE SIGNED <b>7/15/58</b>	
PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus, M.D.</b>		<b>Springfield Hospital</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-19-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Springfield</b>		22d. LOCATION (City, town, or county) (State) <b>Sykesville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur A. Haight</b>		24a. REC'D BY REGISTRAR <b>Jul 21 '58</b>	
ADDRESS <b>Sykesville, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Alfred</b>	

## HARVARD STATE DEPARTMENT OF HEALTH-PATIENTS 18

Fig. 2

1



## 7847

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Balto. City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>2yrs. 10mos. 21days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		<b>3V01-4</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>4033 Falls Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>William Franklin SHAUCK</b>				4. DATE OF DEATH Month Day Year <b>July 30, 1958</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>February 19, 1878</b>	
				9. AGE (In years last birthday) yrs. <b>80</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Lampighter</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>BALTO. CITY</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		(If yes, give war or dates of service) <b>-</b>		16. SOCIAL SECURITY NO. <b>215-05-9208</b>		17. INFORMANT <b>Springfield Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>491X</b> <del>XXXX</del> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Arteriosclerotic heart disease</b> <b>DUE TO</b> (c) <b>Generalized arteriosclerosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Days</b> <b>Years</b> <b>Years.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE IMMEDIATE DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. assoc. with dist. of metabolism, growth or nutrition, with senile brain disease with psychotic reaction. Secondary anemia.</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>September 9, 1955</b> to <b>July 30, 1958</b> , that I last saw the deceased alive on <b>July 30, 1958</b> , and that death occurred at <b>8:45A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>7/30/58</b>							
ACTUAL SIGNATURE <b>Agustin del Campo</b>		M.D. <b>Springfield State Hospital</b>					
PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>		<b>Sykesville, Maryland</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug 3 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St Marys</b>		22d. LOCATION (City, town, or county) (State) <b>Balto.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Paul E. Chas...</b>		ADDRESS <b>3615-17-19 Chestnut</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 1 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Al...</b>	

**VS**  
**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

VS A15 (4)  
15M 10/57





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the State Board of Health. Page 5 should be used as a burial-transit permit. File pages 1 and 2 in the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

VS. A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
7848 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07846

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL WESTMINSTER</u>		c. LENGTH OF STAY IN 1b <u>11</u> d. STREET ADDRESS <u>FOUNTAIN VALLEY</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL WESTMINSTER</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>IMMIDIPS CHURCH</u>		4. DATE OF DEATH Month <u>JULY</u> Day <u>27</u> Year <u>1958</u>	
3. NAME OF DECEASED (Type or print) <u>JULIA LOUISE STARNER</u>		5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>AUG 4 1892</u> 9. AGE (in years for birthday) <u>65</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MD</u> 11. BIRTHPLACE (State or foreign country) <u>MD</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>HARRY LITTLE</u>		14. MOTHER'S MAIDEN NAME <u>ANNIE KOONTZ</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u> 17. INFORMANT <u>PAUL STARNER</u> Address <u>FOUNTAIN VALLEY WESTMINSTER MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY SCLEROSIS</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X DIABETES MELLITUS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>MIN</u> <u>YEARS</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>o. m.</u> <u>p. m.</u> <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James J. Marsh</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JAMES T. MARSH</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>7/27/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JULY 31/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>TRIDETS CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>WESTMINSTER MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>David L. Bankard Westminster Md</u>		24a. REC'D BY REGISTRAR <u>DATE JUL 30 '58</u> 24b. REGISTRAR'S SIGNATURE <u>Carl Smith</u>	

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
OFFICE OF THE STATE COMMISSIONER OF HEALTH  
ALBANY, N. Y.

NEW YORK STATE DEPARTMENT OF HEALTH—BUREAU OF VITAL STATISTICS  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH	
JAMES J. JONES		35		M		W		JAN 15 1910	
RESIDENCE		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE	
100 W. 10th St. N. Y. C.		100 W. 10th St. N. Y. C.		HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE	
OCCUPATION		EDUCATION		RELIGION		MARITAL STATUS		PREVIOUS ILLNESS	
Clerk		High School		Catholic		Married		None	
DATE OF BIRTH		PLACE OF BIRTH		DATE OF ENTRY INTO STATE		DATE OF ENTRY INTO COUNTRY		DATE OF ENTRY INTO CITY	
JAN 15 1875		N. Y. C.		JAN 15 1895		JAN 15 1875		JAN 15 1875	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE	
JAN 15 1910		100 W. 10th St. N. Y. C.		HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE	
OCCUPATION		EDUCATION		RELIGION		MARITAL STATUS		PREVIOUS ILLNESS	
Clerk		High School		Catholic		Married		None	
DATE OF BIRTH		PLACE OF BIRTH		DATE OF ENTRY INTO STATE		DATE OF ENTRY INTO COUNTRY		DATE OF ENTRY INTO CITY	
JAN 15 1875		N. Y. C.		JAN 15 1895		JAN 15 1875		JAN 15 1875	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE	
JAN 15 1910		100 W. 10th St. N. Y. C.		HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE	
OCCUPATION		EDUCATION		RELIGION		MARITAL STATUS		PREVIOUS ILLNESS	
Clerk		High School		Catholic		Married		None	
DATE OF BIRTH		PLACE OF BIRTH		DATE OF ENTRY INTO STATE		DATE OF ENTRY INTO COUNTRY		DATE OF ENTRY INTO CITY	
JAN 15 1875		N. Y. C.		JAN 15 1895		JAN 15 1875		JAN 15 1875	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7849

## CERTIFICATE OF DEATH

07847

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Henryton</b>		c. LENGTH OF STAY IN lb <b>141 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Henryton State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Stevenson</b> Last <b>Stevenson</b>		4. DATE OF DEATH Month <b>July</b> Day <b>29</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-5-1872</b>
9. AGE (In years last birthday) <b>85 yrs.</b>		10. IF UNDER 1 YEAR: Months <b>85</b> Days <b>85</b> Hours <b>85</b> Min. <b>85</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dorchester Co., Md.</b>	
11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Georgianna Harris</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-32-4444</b>	
17. INFORMANT <b>John Stevenson - Patient</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>Cardio-vascular insufficiency</b> IMMEDIATE CAUSE (a) <b>002X</b> DUE TO <b>Aneurysm of the aorta</b> (b) <b>pulmonary tuberculosis</b> DUE TO <b>pulmonary tuberculosis</b> (c) <b>pulmonary tuberculosis</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>002X</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 10,</b> 19 <b>58</b> , to <b>July 29,</b> 19 <b>58</b> , that I last saw the deceased alive on <b>July 29,</b> 19 <b>58</b> , and that death occurred at <b>8:15 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>E. M. Maculans M. D.</b>		ADDRESS (Street, city or town, state) <b>Henryton, Maryland</b> DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>E. M. Maculans, M. D., Supt.</b>		<b>Henryton State Hospital, Henryton, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-2-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Ashbury Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Loreley, Balto. Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard K. McLaughlin</b>		24a. REC'D BY REGISTRAR <b>Alfred H. Search</b> 24b. REGISTRAR'S SIGNATURE <b>Alfred H. Search</b>	
ADDRESS <b>Abingdon Md</b>		DATE <b>JUL 31 '58</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4.

may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completed, page 3 should be detached for filing in the burial transit permit. Then please remove carbon papers.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, page 3 should be detached for filing in the burial transit permit. Then please remove carbon papers.

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

512

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

## CERTIFICATE OF DEATH

Reg. Dist. No.

07848

7850

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>2 y 6 m 8 d</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Ellen Amelda Sullivan</b>		4. DATE OF DEATH Month Day Year <b>7 12 1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>3-31- 86</b>
9. AGE (In years last birthday) yrs. <b>72</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>72</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Ireland</b>		12. CITIZEN OF WHAT COUNTRY? <b>Naturalized</b>	
13. FATHER'S NAME <b>Timothy Hurley</b>		14. MOTHER'S MAIDEN NAME <b>Nora Curran Hurley</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>unkn</b>	
17. INFORMANT <b>S.S.Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>491 X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pulmonary tuberculosis, minimal, inactive</b> DUE TO (c) <b>Schizophrenic reaction, paranoid type. Fracture intertrochanteric, left femur</b> <b>002 X</b>			INTERVAL BETWEEN ONSET AND DEATH <b>days</b> <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Schizophrenic reaction, paranoid type. Fracture intertrochanteric, left femur</b> <b>002 X</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>Fell from wheelchair</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>4 11 58</b> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <b>on ward</b>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>on ward</b>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1-4-</b> 19 <b>56</b> , to <b>7-12-</b> 19 <b>58</b> , that I last saw the deceased alive on <b>7- 11-</b> 19 <b>58</b> , and that death occurred at <b>8:30 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Julian Radzykewytch</b> M.D.		ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>7-12-58</b>	
PHYSICIAN'S NAME (Type) <b>Julian Radzykewytch M.D.</b>		<b>Sykesville, Maryland.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7-16-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Gerald N. Minnich</b>		24a. REC'D BY REGISTRAR <b>Hagerstown</b> DATE <b>JUL 15 '58</b>	24b. REGISTRAR'S SIGNATURE <b>W. J. ...</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

1918

Register of

Deaths

Number

County

Age

Sex

Occupation

Place of Birth

Place of Death

Age

Sex

Occupation

Age

Sex

Occupation

Place of Birth

Place of Death

Place of Death

Place of Birth

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Place of Birth

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07849

7851

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b> c. LENGTH OF STAY IN 1b <b>15 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>City</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 18, Md.</b> d. STREET ADDRESS <b>2803 Guilfoerd Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Helen Elizabeth Sutton</b>		4. DATE OF DEATH Month <b>7</b> Day <b>13</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-13-65</b>
9. AGE (In years by birthday) <b>93</b> yrs.		IF UNDER 1 YEAR: Months <b>93</b> Days <b>93</b> Hours <b>93</b> Min. <b>93</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>aryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Samuel E. Kirk</b>		14. MOTHER'S MAIDEN NAME <b>Martha Cole</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>unkn</b>	
17. INFORMANT <b>S.S. Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> DUE TO <b>420.0</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>C.B.S. assoc. with cerebral arterioscler.</b> (c) <b>C.B.S. assoc. with cerebral arterioscler.</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>years</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6-28-</b> , 19 <b>58</b> , to <b>7-13-</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>7-12-</b> , 19 <b>58</b> , and that death occurred at <b>6:31 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Edmund Lusthaus</b> M.D.		ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b>	
DATE SIGNED <b>7-13-58</b>			
PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus M.D.</b>		<b>Sykesville, Maryland.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 15, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. SANDER &amp; SONS, INC, Baltimore, Md.</b>		24a. REC'D BY REGISTRAR <b>Jul 16 58</b>	
ADDRESS <b>H. SANDER &amp; SONS, INC, Baltimore, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>W. L. Sander</b>	

25. FROM THE 17th TO THE 19th OF MAY 1941

7852

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 13, Md.</b>	
c. LENGTH OF STAY IN 1b <b>1 y 2 m 15 d</b>		d. STREET ADDRESS <b>3010 Kenyon Avenue</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Lillian</b> Middle <b>Valeria</b> Last <b>Trueblood</b>		4. DATE OF DEATH Month <b>7</b> Day <b>5</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-4-76</b>
9. AGE (In years last birthday) <b>82</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Theodore Perry</b>		14. MOTHER'S MAIDEN NAME <b>Ida Banke</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>unkn</b>	
17. INFORMANT <b>S.S. Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>491X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Nephritis due to Septicemia</b> <b>100Xα</b> (c) <b>Dacubitus Ulcer</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>days</b> <b>weeks</b> <b>weeks</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>7147</b> <b>C.B.S. assoc. with cerebral arteriosclerosis, with psych. reaction</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Pt. fell injuring right hip</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>6 4 58</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>ward</b>		20f. (City or town) (County) (State) <b>S.S. Hospital, Sykesville, Md.</b>	
21. I certify that I attended the deceased from <b>4-20-</b> 19 <b>57</b> , to <b>7-4-</b> 19 <b>58</b> , that I last saw the deceased alive on <b>7-4-</b> 19 <b>58</b> , and that death occurred at <b>2:20 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>7-5-58</b>			
ACTUAL SIGNATURE <b>Edmund Lusthaus</b> M.D. <b>Springfield State Hospital</b>			
PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus M.D.</b> <b>Sykesville, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7-8-1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lassahn Funeral Home</b>		24a. REC'D BY REGISTRAR <b>JUL 8 '58</b>	24b. REGISTRAR'S SIGNATURE <b>W. K. Smith</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached from this certificate as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for filing as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18																			
7853																			
Film G231 7/22/58 Items22abc8																			
CERTIFICATE OF DEATH																			
Reg. Dist. No. 07851																			
1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>														
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Henryton</b>					c. LENGTH OF STAY IN 1b <b>2 days</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Beaver Heights</b> 16 X-2 ✓									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Henryton State Hospital</b>					d. STREET ADDRESS <b>4612 R Street</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <b>Daniel</b> Middle <b>Tyler</b> Last <b>Tyler</b>					4. DATE OF DEATH Month <b>July</b> Day <b>17</b> Year <b>19 58</b>														
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 3, 1915</b>		9. AGE (In years last birthday) <b>43</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cab Driver</b>					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) <b>Orangeburg, S. C.</b>					12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				
13. FATHER'S NAME <b>Mack Tyler</b>					14. MOTHER'S MAIDEN NAME <b>Luellen Jamison</b>														
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>					16. SOCIAL SECURITY NO. <b>Unknown</b>					17. INFORMANT <b>Beatrice Tyler-Wife</b> Address <b>4612 R Street</b>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cereberal vascular disease</b> 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Meningitis or cereberal tumor</b> DUE TO (c) <b>Far advanced pulmonary tuberculosis</b>										INTERVAL BETWEEN ONSET AND DEATH									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)														
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <b>July 16, 19 58</b> to <b>July 17, 19 58</b> that I last saw the deceased alive on <b>July 17, 19 58</b> , and that death occurred at <b>7:25 p. M.</b> from the causes and on the date stated above. <b>E. M. Maculans M.D.</b> ADDRESS (Street, city or town, state) <b>Henryton, Maryland</b> DATE SIGNED <b>7-17-58</b>																			
ACTUAL SIGNATURE					PHYSICIAN'S NAME (Type) <b>Dr. E. M. Maculans, Supt. Henryton State Hospital, Henryton, Md.</b>														
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>					22b. DATE THEREOF <b>7/21/58</b>					22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cem.</b>					22d. LOCATION (City, town, or county) (State) <b>Washington, D. C.</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <b>Petworth Fun Home TSC</b>					ADDRESS <b>814 - upland</b>					24a. REC'D BY REGISTRAR DATE <b>JUL 21 '58</b>					24b. REGISTRAR'S SIGNATURE <b>Wash DC</b>				

THIS

CERTIFICATE OF DEATH

NO. 1000

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		35		Jan 1, 1900		New York City	
Cause of Death		Immediate Cause		Underlying Cause		Manner of Death		Place of Death	
Heart Disease		Myocardial Infarction		Coronary Atherosclerosis		Natural		New York City	
Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Jan 15, 1935		10:00 AM		New York City		[Signature]		[Signature]	
Occupation		Education		Marital Status		Previous Illnesses		Previous Operations	
Teacher		High School		Married		Hypertension		None	
Usual Residence		Usual Address		Usual Telephone		Usual Physician		Usual Hospital	
123 Main St		New York City		123-4567		Dr. Smith		St. Mary's	
Date of Report		Time of Report		Place of Report		Signature of Reporter		Signature of Registrar	
Jan 16, 1935		11:00 AM		New York City		[Signature]		[Signature]	

# 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100 101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157 158 159 160 161 162 163 164 165 166 167 168 169 170 171 172 173 174 175 176 177 178 179 180 181 182 183 184 185 186 187 188 189 190 191 192 193 194 195 196 197 198 199 200 201 202 203 204 205 206 207 208 209 210 211 212 213 214 215 216 217 218 219 220 221 222 223 224 225 226 227 228 229 230 231 232 233 234 235 236 237 238 239 240 241 242 243 244 245 246 247 248 249 250 251 252 253 254 255 256 257 258 259 260 261 262 263 264 265 266 267 268 269 270 271 272 273 274 275 276 277 278 279 280 281 282 283 284 285 286 287 288 289 290 291 292 293 294 295 296 297 298 299 300 301 302 303 304 305 306 307 308 309 310 311 312 313 314 315 316 317 318 319 320 321 322 323 324 325 326 327 328 329 330 331 332 333 334 335 336 337 338 339 340 341 342 343 344 345 346 347 348 349 350 351 352 353 354 355 356 357 358 359 360 361 362 363 364 365 366 367 368 369 370 371 372 373 374 375 376 377 378 379 380 381 382 383 384 385 386 387 388 389 390 391 392 393 394 395 396 397 398 399 400 401 402 403 404 405 406 407 408 409 410 411 412 413 414 415 416 417 418 419 420 421 422 423 424 425 426 427 428 429 430 431 432 433 434 435 436 437 438 439 440 441 442 443 444 445 446 447 448 449 450 451 452 453 454 455 456 457 458 459 460 461 462 463 464 465 466 467 468 469 470 471 472 473 474 475 476 477 478 479 480 481 482 483 484 485 486 487 488 489 490 491 492 493 494 495 496 497 498 499 500 501 502 503 504 505 506 507 508 509 510 511 512 513 514 515 516 517 518 519 520 521 522 523 524 525 526 527 528 529 530 531 532 533 534 535 536 537 538 539 540 541 542 543 544 545 546 547 548 549 550 551 552 553 554 555 556 557 558 559 560 561 562 563 564 565 566 567 568 569 570 571 572 573 574 575 576 577 578 579 580 581 582 583 584 585 586 587 588 589 590 591 592 593 594 595 596 597 598 599 600 601 602 603 604 605 606 607 608 609 610 611 612 613 614 615 616 617 618 619 620 621 622 623 624 625 626 627 628 629 630 631 632 633 634 635 636 637 638 639 640 641 642 643 644 645 646 647 648 649 650 651 652 653 654 655 656 657 658 659 660 661 662 663 664 665 666 667 668 669 670 671 672 673 674 675 676 677 678 679 680 681 682 683 684 685 686 687 688 689 690 691 692 693 694 695 696 697 698 699 700 701 702 703 704 705 706 707 708 709 710 711 712 713 714 715 716 717 718 719 720 721 722 723 724 725 726 727 728 729 730 731 732 733 734 735 736 737 738 739 740 741 742 743 744 745 746 747 748 749 750 751 752 753 754 755 756 757 758 759 760 761 762 763 764 765 766 767 768 769 770 771 772 773 774 775 776 777 778 779 780 781 782 783 784 785 786 787 788 789 790 791 792 793 794 795 796 797 798 799 800 801 802 803 804 805 806 807 808 809 810 811 812 813 814 815 816 817 818 819 820 821 822 823 824 825 826 827 828 829 830 831 832 833 834 835 836 837 838 839 840 841 842 843 844 845 846 847 848 849 850 851 852 853 854 855 856 857 858 859 860 861 862 863 864 865 866 867 868 869 870 871 872 873 874 875 876 877 878 879 880 881 882 883 884 885 886 887 888 889 890 891 892 893 894 895 896 897 898 899 900 901 902 903 904 905 906 907 908 909 910 911 912 913 914 915 916 917 918 919 920 921 922 923 924 925 926 927 928 929 930 931 932 933 934 935 936 937 938 939 940 941 942 943 944 945 946 947 948 949 950 951 952 953 954 955 956 957 958 959 960 961 962 963 964 965 966 967 968 969 970 971 972 973 974 975 976 977 978 979 980 981 982 983 984 985 986 987 988 989 990 991 992 993 994 995 996 997 998 999 1000

7854

## CERTIFICATE OF DEATH

07852

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville, Maryland</b>				c. LENGTH OF STAY IN 1b <b>1yr. 1mo. 29days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Wilburt</b> Middle <b>David</b> Last <b>Vester</b>				4. DATE OF DEATH Month <b>7</b> Day <b>23</b> Year <b>1958</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/26/73</b>		9. AGE (In years last birthday) <b>84</b> yrs.	10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Insurance Man</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Christopher Vester</b>				14. MOTHER'S MAIDEN NAME <b>Katharine Spencer</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>215-01-3600</b>		17. INFORMANT <b>Springfield State Hospital, Sykesville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal bronchopneumonia</b> <b>491X</b> Not due to (b) <b>Arteriosclerotic cardiac-vascular and cerebral disease</b> years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Generalized arteriosclerosis</b> years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5/24</b> , 19 <b>57</b> , to <b>7/23</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>7/23</b> , 19 <b>58</b> , and that death occurred at <b>6:35 p.m.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield State Hospital, Sykesville,</b> DATE SIGNED <b>Agustin del Campo</b>							
ACTUAL SIGNATURE <b>Agustin del Campo</b>				PHYSICIAN'S NAME (Type) <b>Agustin del Campo</b> M.D. <b>Springfield State Hospital, Sykesville,</b> <b>Maryland, July 24, 1958</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 26, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HENRY SANDER &amp; SONS, INC.</b>				24a. REC'D BY REGISTRAR <b>JUL 28 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. J. Smith</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached from the certificate as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 7855 CERTIFICATE OF DEATH

Reg. Dist. No.

07853

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto.Co.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN lb <b>30yrs.2mos.3days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>Unknown</b>			
3. NAME OF DECEASED (Type or print) First <b>Ross</b> Middle <b>C.</b> Last <b>WIEST</b>				4. DATE OF DEATH Month <b>July</b> Day <b>7</b> Year <b>1958</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 21, 1905</b>	
9. AGE (In years last birthday) <b>53</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Wm. R. Wiest</b>				14. MOTHER'S MAIDEN NAME <b>Maud O. Miller</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Springfield Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic carcinoma of the lung</b> 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma of the colon</b> DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <b>Months</b> <b>Months</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Dementia Praecox, hebephrenic</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>March 7, 1955</b> to <b>July 7, 1958</b> , that I last saw the deceased alive on <b>July 7, 1958</b> , and that death occurred at <b>7:20 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Agustin del Campo</b> M.D.				ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b>			
PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>				DATE SIGNED <b>7/8/58</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/10/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Dickner</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 9 '58</b>			
24b. REGISTRAR'S SIGNATURE <b>Wm. J. Dickner</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached from this certificate as the burial-transit permit. Then please remove carbon paper from pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES J. JONES		Male		35		Jan 15, 1900		New York City	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
123 Main St., New York City		Clerk		Heart Disease		Natural		New York City	
DATE OF DEATH		TIME OF DEATH		HOURS OF DEATH		MINUTES OF DEATH		SECONDS OF DEATH	
Jan 20, 1935		10:30 AM		10		30		00	
PLACE OF DEATH		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
New York City		Clerk		Heart Disease		Natural		New York City	
DATE OF DEATH		TIME OF DEATH		HOURS OF DEATH		MINUTES OF DEATH		SECONDS OF DEATH	
Jan 20, 1935		10:30 AM		10		30		00	
PLACE OF DEATH		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
New York City		Clerk		Heart Disease		Natural		New York City	

7856

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Sykesville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>1810 St. Paul Street</b>	
3. NAME OF DECEASED (Type or print) First <b>William ASH</b> Middle <b>WILSON</b> Last <b>WILSON</b>		4. DATE OF DEATH Month <b>7</b> Day <b>3</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/1/80</b>
9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Stationary Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>unknown</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>William Wilson</b>	
14. MOTHER'S MAIDEN NAME <b>Grace Peacock</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>gmk</b>	
16. SOCIAL SECURITY NO. <b>218-10-5602</b>		17. INFORMANT <b>Record, Springfield State Hospital</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>491X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic heart disease</b> (c) <b>Diabetes Mellitus</b>			INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b> <b>years</b> <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CBS assoc. with senile brain disease, with psychotic reaction</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>---</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6/17</b> , <b>1958</b> to <b>7/3</b> , <b>1958</b> , that I last saw the deceased alive on <b>7/2</b> , <b>1958</b> , and that death occurred at <b>12.55A DST</b> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Gertrude M. Gross</b>		ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b>	
PHYSICIAN'S NAME (Type) <b>Gertrude M. Gross, M. D.</b>		DATE SIGNED <b>7/3/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-4-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Springfield</b>		22d. LOCATION (City, town, or county) (State) <b>Sykesville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert H. Haight</b>		24a. REC'D BY REGISTRAR <b>DATE JUL 9 '58</b>	
ADDRESS <b>Sykesville, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>W. J. Smith</b>	



## 7857 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>			c. LENGTH OF STAY IN 1b <b>2 yrs. 17 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Boonsboro</b> <i>2/15-2</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>RFD</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Romer</b> Middle <b>Calvin</b> Last <b>YOUNKINS</b>				4. DATE OF DEATH Month <b>July</b> Day <b>9,</b> Year <b>19 58</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 16, 1872</b>		
9. AGE (In years last birthday) <b>85</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Carl Younkings</b>				14. MOTHER'S MAIDEN NAME <b>Ella Sigler</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT Address <b>Springfield Hospital Records</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <b>Days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. assoc. with senile brain disease with psychotic reaction.</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 22,</b> 19 <b>56,</b> to <b>July 9,</b> 19 <b>58,</b> that I last saw the deceased alive on <b>July 9,</b> 19 <b>58,</b> and that death occurred at <b>10:15 A.M.</b> from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>Agustin del Campo</i> M.D.				ADDRESS (Street, city or town, state) <b>Springfield Hospital</b>		DATE SIGNED <b>7/9/58</b>		
PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>				Sykesville, Md.				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-11-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lutheran Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Middle town</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ray C. Deladillo</i>				ADDRESS <b>Middle town</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 14 '58</b>		
				24b. REGISTRAR'S SIGNATURE <i>Alfred Smith</i>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician, after the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

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